# A STUDY TO ASSESS THE KNOWLEDGE OF HIGH SCHOOL TEACHERS REGARDING SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS IN A SELECTED HIGH SCHOOL AT SALEM DISTRICT, TAMILNADU

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# CERTIFICATE

This to certify that, this thesis, titled **"A STUDY TO ASSESS THE KNOWLEDGE OF HIGH SCHOOL TEACHERS REGARDING SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS IN A SELECTED HIGH SCHOOL AT SALEM DISTRICT, TAMILNADU"** submitted by **Ms.UDHAYAKUMARI, M.Sc (Nursing) (2009 – 2011 Batch)** Vivekanandha College of Nursing in partial fulfillment of the requirement of the Degree of Master of Science (Nursing) from the Tamilnadu Dr.M.G.R. Medical University is her original work carried out under our guidance.

This thesis or any part of it has not been previously submitted for any other Degree or Diploma.

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# DECLARATION

*I hereby declare that this thesis entitled* **"A STUDY TO ASSESS THE KNOWLEDGE OF HIGH SCHOOL TEACHERS REGARDING SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS IN A SELECTED HIGH SCHOOL AT SALEM DISTRICT, TAMILNADU"** *is the outcome of the original work undertaken and carried out by me under the guidance and direct supervision of* **Prof. Mrs. R.KANAGAVALLI, M.Sc (N), (Ph.D.,)** *and Speciality Guide* **Prof.Mrs. L. PARIMALA DEVI, M.Sc(N).,** *Department of Child Health Nursing, Vivekanandha College of Nursing, (Sponsored by Angammal Educational Trust), Elayampalayam, Tiruchengode, Namakkal District.*

*I also declare that the material of this thesis has not formed in any way the basis for award of any other Degree, Diploma or Associate fellowship previously of the Tamil Nadu Dr. M.G.R. Medical University.*

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# ABSTRACT

The thesis title **"A STUDY TO ASSESS THE KNOWLEDGE OF HIGH SCHOOL TEACHERS REGARDING SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS IN A SELECTED HIGH SCHOOL AT SALEM DISTRICT"** was conducted by **Ms. V.UDHAYAKUMARI** in partial fulfillment of the requirement for the degree of master of nursing during the year 2009-2011.

**THE OBJECTIVES OF THE STUDY ARE**

1. To assess the knowledge of high school teachers regarding selected behavioural problems of adolescents.
2. To determine the relationship between the knowledge of high school teachers on selected behavioural problems with selected demographic variables such as age, sex, educational qualification, teaching experience.
3. To prepare health education pamphlet regarding selected behavioural problems among adolescents.

The research approach adopted for the study was descriptive in nature 40 high school teachers from Velasamy Chettiar Higher Secondary school were selected for the study.40 teachers were selected for this study by convenience sampling method.

A semi-structured questionnaire was developed to collect data from the sample, it had 2 parts, Part A deals with Socio -demographic variables of the teachers. Part B contain 3 sections consists of 216 questions to assess the knowledge of high school teachers regarding causes, signs and symptoms, management and prevention of behavioural problems of adolescents.

Collected data was analyzed by using descriptive and inferential statistics in terms of frequencies percentage, mean, standard deviation and Chi-square analysis.

**SUMMARY OF THE MAJOR FINDINGS**

**Findings related to sample characteristics**

Among 40 samples,26(65%) were below 40 years of age,14(35%) were above 40 years,18(45%) were males and 22(55%) were females,19(47.5%) teachers have master degree withB.Ed,17(42.5%) of them have master degree with M.Ed,4(10%) of them teachers have master degree with M.Phil,30(75%) had below 15 years of experience,10(25%) had above 15 years of experience,28(70%) were deals with XI,XII standard,40(100%) teachers had child psychology in their curriculum,22(55%) of them have participated in the inservice education on child psychology.

**Findings related to knowledge score of teachers**

The overall knowledge score of teachers regarding conduct disorder, emotional disorder, substance abuse were 34.09%. The mean score percentage of knowledge of teachers regarding conduct disorder was about 37.14%. The mean score percentage of knowledge of teachers regarding emotional disorder about 32.73%.The mean score percentage of teachers regarding substance abuse was about 33.76%.

**Findings regarding the relationship between the selected demographic variables and knowledge level of teachers**

Chi –square analysis was applied to compare the knowledge with selected social demographic variables. Result shows that age, education, teaching experience, participation in inservice education programme on child psychology are significant at 5% ($P<0.05$) level. Other demographic variables like sex, deals with which standard of children are not significant at 5% level.

**Based on th ese findings the following recommendations were made**

1. A quasi-experimental study can be done to observe the effect of programmed instruction on knowledge and skill of teachers in school health programme.
2. A formal continuing education programme must be conducted in all schools regarding selected behavioural problems among adolescents, it's identification and management.

3. A concentrated effort should be made by community health nurse to increase awareness among high school teachers and their role in the total school health services.
4. A comparative study may be conducted between rural and urban teachers regarding the knowledge on behavioural problems of adolescents.
5. A similar study may be done on nurses to find out their knowledge and role perception about behavioural problems of adolescents.
6. A study can be conducted in the community to identify the prevalence of behavioural problems among adolescents.
7. A similar study can be conducted to assess the knowledge of parents regarding behavioural problems of adolescents.
8. The study can be replicated using a large sample there by findings can be generalized to a large population.
9. A study can be carried out to assess the knowledge, attitude of teachers regarding emotional needs of adolescents.

An information booklet was developed for teachers regarding the selected behavioural problems among adolescent.

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# CHAPTER I

# INTRODUCTION

***"Adolescence is a period of life that present***

***Special challenges of adjustments".***

***- Whaley and Wong, 2008***

Life cycle of human organism under goes various kinds of developmental changes. Though every stage of life cycle is considered to be very important some stages are very vital in nurturing the personality development of an individual.

Development is a lifelong process. Adolescence is the period that begins with the onset puberty and end at the age of 19 years.

Adolescence is the period of life between childhood and adulthood. During this transition period, dramatic physical, cognitive, psychosocial and psychosexual changes take place that are exciting and at the same time frightening.

The term "adolescence" is derived from Latin word "Adolescere" meaning "to change", "to grow", "to mature". It also means "to emerge" or "achieve identity" and is the most challenging and critical times of one's life. Drastic physical, psychological and social transformation and maturation characterize adolescence.

Adolescence is the most important period in one's life. It is a period of stress and strain, of day dreams, intense affection and excitement. The mind is pious and pure, free from all wickedness. It is full of love and showers its affection on anyone without any pre-thinking.

Adolescent period is defined by the WHO, as age group between 10 and 19 years of age. This can be further divided into early (10-13years), middle (14-16 years), and late (17-19 years) adolescence. The age group between 15 and 24 years are termed "youth" and together the two groups are termed "young people" (10-24 years).

The onset of puberty brings dramatic changes to the body and mind. (Dhal, 2004)

Large pulses in sex hormones change feelings and interests as well as the body. Major brain growth, reorganization, and interconnectedness occur within multiple regions of the brain that will extend into young adulthood. (Giedd, 2004)

The adolescent tryout many new roles during this time as part of the important developmental task of identity formation. The peer group is utmost importance as adolescent experiments with new roles outsides the confines of the family unit. Adolescence is considered as a "period of transition from childhood to adulthood." They are no longer children yet not adults. Adolescent cravings for strong emotional experiences are reflected in their enjoyment of loud music, horror movies, and extreme

amusement park rides. Although their cognitive skills are nearly at adult levels their ability to make good decisions under the influence of strong emotions is poor. (Dhal, 2004)

World Health organization refers to people aged 10-19 years of adolescent's. The total global population of 6.3 billion (630 crores), 1.2 billion (120 crores) are adolescents. In India as per 2002 census there are 225 million adolescents comprising nearly 22% of total population out of which 12% belong early adolescence (10-14 years) and 10% to the total late adolescent age group (15-19 years).

In India, there are more than 230 million adolescents, which is approximately 23 % of the total population. The sex ratio of females to males is 927 per 1000 males.

They are not only in large number but also the citizens and workers of tomorrow. The swiftly changing global conditions are placing a great strain on the young people modifying their behavior and relationships and exacerbating their health problems. Healthy and developed adolescents have a better chance of becoming healthy responsible and productive adults.

Adolescents are regarded as one of the most valuable assets of any society. Such an emphasis is obviously based on the potential of the adolescents to contribute intellectually, politically and economically to the society.

Their willingness and readiness to any kind of adjustment and a sense of well being are crucial factors for their positive contribution to the society, adolescence period of intense socializing. Adolescence is the stage that the social relationship attains heightened significance. They need an opportunity for reflection in order to gain perspective and the fundamental issues of life as they are related to living with others.

Adolescent period is filled with anxiety, frustration, identity crisis, looking out for support and a struggle between dependency needs and independence. The emotional turn oil goes hand in hand with the physiological changes that occur in the body. This phase in life is a highly vulnerable period because of simultaneous interaction of the bio-psychosocial factors. Hence adolescent from a risk group of the community. Ability to cope with and perform the expected roles in this age group depend "Homeostasis" in family environment and personality.

Adolescence is characterized by adolescent growth spurt (i.e) an acceleration of growth in most skeletal dimensions and in many internal organs, changes in body composition (i.e) in the quantity and distribution of fat and musculature. These changes are associated with the development of gonads, reproductive organs and secondary sex characters. (Piyush Gupta, 2007)

Adolescence is that it is a period between the age of 10 & 25 years of bio-psychosocial maturation leading to functional independence in adult life. (Russell Viner, 1998)

National policy of education1986 said that 7.5% of total school curriculum had been allotted to health education in teacher training course. They had a lack of co-ordination between state council of education, research, training and state school health bureau. So the teachers were not getting adequate training in health aspect.

The 9th conference of central council of health and central family welfare resolved that the teachers in primary and higher secondary classes should be trained to observe and screen the students for detect and deviation from normal physical and mental health to maintain effective surveillance. The supportive training programme can be planned for the teachers about prevention and to develop desirable psychosocial well being with the group and to the society.

The school is psychologically important to adolescents as a focus of a social life. Teenagers usually distribute themselves into a relatively predictable social hierarchy. They know to which groups they and others belong. A sense of school connectedness and optimal social connectedness and optimal social connectedness is associated with positive outcomes for school completion, positive mood, and decreased high risk behaviour in adolescent. (Bond, et.al, 2007)

School connectedness is correlated with caring teachers and the absence of prejudice or discrimination from peers. The sense of school connectedness is less dependent on class size, attendance, academic preparation and parental involvement. (Males and Lievens, 2003)

If an adolescent does not enter puberty at the same time as his or her peers considerable inner conflict may occur. Early maturing girls and boys have higher rates of sexual risk taking behaviours, delinquency and substance abuse than their on time peers. (Costello, et.al, 2007)

The teachers are the capable person to identify the behavioural problems of adolescent. The teachers will promote psychosocial competencies like decision making, problem solving, critical and creative thinking, interpersonal relationship skills, self awareness, empathy and skills for coping with emotional stress among adolescence. "It is the personality of the teachers and their attitude towards students more than teaching that constitute the crux of mental health in school". (Bernard, W.H, 1970)

Mental health programmes in schools are effective in identifying the children with behavioural problems early and target them for intervention. Teachers have often received some training in mental health programmes and problems of the children. This makes the teachers to become potentially well qualified in identification of behavioural problems among adolescence and planning the remedial mental health

programmes. The mental health programmes helps to improve the coping skills, decrease the stress and increase the psychosocial well being of the adolescence.

Findings ways to nurture and augment the mental health of youth is an important responsibility of teachers who by virtue of their close contact with adolescence and their capacity to modify behavior are a powerful group of people.

Jellinek, et.al, (2002) concerns for the adolescent include engaging in high risk behaviour, such as sex, alcohol and drug use, driving while intoxicated and using tobacco products in addition to aggressive or hostile behaviour, depressed mood, and school absenteeism or academic failure.

Rao, A.R, (1995) estimated that in India the age group between 10 and 20 years occupies 1/3 of total population.

Mohan Issac, (1999) also states that there are few epidemiological studies which quote 15-20% of students are having recognizable mental disorders in the forms of depression, anxiety, alcoholism and drug abuse.

Children between 11-19 years of age group spend most of their time I in the school. School is the place where growing children come to grips with their emotional integration into the larger society. According to who (1994) schools have an unrestricted opportunity to improve the lives of young people school are aiming the full support of families and community are needed to provide comprehensive mental health to the

children schools can act as a safety net to provide the children from hazards that affect their learning and promote wellbeing of the children.

Gutgesell, (2004) failure to set appropriate limits and expectations, lack of pride in the adolescent's achievements, negative affect towards the adolescent, frustration or anger with the normal level of adolescent mood liability and failure to support the adolescent's positive engagement in the community and school signal problem the parent- adolescent relationship.

Behavioural problems in adolescents includes conduct disorder, emotional disorders, substance abuse can be caused by genetics, chemical imbalances, damage to the central nervous system, exposure to environmental toxins such as high levels of lead, exposure to violence, stress, divorce of parents, lack of support and conducive environment in home, community and school. The appearance of adolescents with behavioural problems are poor concentration, depression, low self esteem, hostility, inability to make good peer relationship, chronic anxiety or feeling of difficulty in handling life.

Conduct disorder (CD) is a repetitive and persistent pattern of behavior in which either the basic rights of others or major age appropriate societal norms and rules are violated. (APA, 2000)

Juvenile delinquent involves wrong doing by a child or a young person who is under age specified by the law of the place concerned.(Sethna, 2008).

Kassinove and Tafrate., (2002) state in contrast to anger aggression is almost always goal directed and has the aim of harm to a specific person or object. Aggression is one of the negative outcomes that may emerge from general arousal and danger.

Mood disorders are disturbances in the regulation of mood, behavior, and affect that go beyond the normal fluctuations that most people experience. (Lippincott Williams, 2004)

Mood is a pervasive and sustained emotion that may have a major influence on a person's perception of the word. It includes depression, joy, elation, anger and anxiety. Affect is described as the emotional reaction associated with an experience. (Taber's 2005)

Mood disorder is a condition where by the prevailing emotional mood is distorted or inappropriate to the specified circumstances. Depression is a form of affective manifestation in which the client will exhibit mood disturbances related to self and his environment.(K.P.Neeraja, 2008)

Anxiety is an emotional response (apprehension, tension, uneasiness) to anticipation of danger, the source of which is largely unknown or unrecognized. Anxiety may be regarded as pathologic when

it interferes with effectiveness in living, achievement of desired goals or satisfaction or reasonable emotional comfort. (Shahrokn & Hales, 2003)

Anxiety is pervasive feeling of dread, apprehension and impending disaster. (K.P.Neeraja, 2008)

Anxiety is a response to an undefined or unknown threat which may be due to unconscious conflict or insecurity. (Bimla Kapoor, 2008)

Suicidal behavior involves thoughts or actions that may lead to self inflicted death or serious injury. (Hodas, Sergent, 1983)

Suicide is the intentional or purposeful taking of one's own life. It is the ultimate act of self destruction. Suicide may be completed, attempted or suicidal ideation. (Nicki Barbara, 2002)

Substance abuse is described as a maladaptive pattern of substance use leading to clinically significant impairment or distress. The substance of abuse may be any chemical substances are alcohol, amphetamines, barbiturates, caffeine, cannabis, cocaine hallucinogens, inhalants, nicotine, sedative hyponotics and anxiolytics and opioids. (Mary C. Townsend, 2006)

In India 5-10 % young people are using substances. Among then 75% of young people are using alcohol and 50% them dependent. Nearly 35% of the young adults are having the habit of smoking. (Dutta, 2007)

Substance abuse may produce unhealthy lifestyles and behaviours chronic substance abuses impair social and occupational functioning, creating personal, professional, financial and legal problems. Substance abuse in early adolescence leads to emotional and behavioural problems including depression, problems with family relationship problems with failure to complete school or studies and develop chronic problems.(Lippincott Williams & Wilkins, 2004)

Substance abuse is the misuse of an addictive substance that changes the user's mental state. The addictive substances commonly abused are tobacco, alcohol and controlled or illicit drugs. Substance abuse usually begins in adolescence. Few people begin tobacco misuse after 18. Half of regular smokers who start in adolescence and smoke all their lives will eventually be killed b tobacco. Alcoholism is a primary chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking. Preoccupation with drug alcohol use of alcohol despite adverse consequences and distortions in thinking most notably denial. (Robert R.Pinger)

Alcohol is a substance prepared by using chemical substances to produce some kind of sedative and anesthetic feeling. Sometimes alcohol is classified as a food because it contains calories without nutritional

value. The sprit content varies for each variety of alcohol beverages. Alcohol exerts a depressant effect on the CNS, resulting in behavioural and mood changes. The effects of alc ohol on the CNS are proportional to the alcoholic concentration in the blood. (Mary C. Townsend, 1998)

Alcoholism is considered as a excessive and compulsive drinking that produces disturbances in mental or cognitive levels of functioning, which interferes with social and economic functioning. (K.P.Neeraja, 2008)

Smoking is a very common behavior among young adults. Nicotine the active ingredient in the tobacco plant is one of the most toxic and addictive drugs known to man. One in 6 deaths in United States are associated with cigarette smoking of adolescents and college students. Drugs used for smoking is not only nicotine nowadays there are other drugs such as cannabis, heroin, cocaine and even some of the lysergic acid diethylamide(LSD) drugs also used for smoking. (Marlow, 2005)

Alcohol (ethanol) is a CNS depressant that reduces the activity of neurons in the brain. In the United States chronic uncontrolled alcohol intake is the largest substance abuse problem. An alcoholic continues to use alcohol despite reduced occupational functioning and negative psychological, social and health consequences.

Nicotine's pharmacokinetic properties enhance its abuse potential. Cigarette smoking rapidly distributes nicotine to the brain, with drug levels peaking within 10 second of inhalation. Acute effects dissipate in a few minutes. So the smoker must continue to dose throughout the day to maintain pleasurable drug effects and prevent withdrawal. (Lippincott Williams, 2004)

High school and college students who experiment with alcohol begin use in a social context and become light or moderate drinkers. Some alcoholics become problem drinkers. That is the individual begin to experience social, legal or financial problems because of their alcohol consumption physical dependence on a alcohol and the loss of control over one's drinking are two important characteristics of alcoholism. The problem of alcohol increases as assault and sexual abuse of women were associated with alcoholism. (Sandip, 2006)

The hazards of smoking at any age are undisrupted. A preventive approach to teenage smoking is especially important. There is a high probability of regular smoking in childhood and adolescence leads to a increased risk of heart diseases, stroke, emphysema and other conditions.

Approximately 5% of 12 to 17 years old males and 12% of 18-25 years old males reported using tobacco for smoking in United States. 57 million U.S residents are current cigarette smokers and 7.6 million used as the smokeless tobacco.20% of teenage girls and boys smoke. The

incidence of smoking is among less educated and those in low socioeconomic group. (Lippincott Wiliams, 2007)

Nicotine is the most psychoactive component found in smoke from tobacco product (cigarettes, cigars, pipes). In India half of the 300 million current smokers die due to tobacco caused diseases. Most of the cigarettes contain at least 10 mg of nicotine. By inhaling smoke, the average smokers takes in 1 to 2 mg of nicotine with each cigarette. (Mohar, 2006)

Psychosocial factors which make the person to chew tobacco are curiosity, social non conformity, poor impulse control, early initiation of tobacco, low self esteem and concerns regarding personal autonomy. They develop tobacco chewing habit due to poor social and familiar support, poor stress management skills, boredom, psychological distress, low self esteem and relief from fatigue. (Niraj Ahuja, 2004)

Tobacco are leaves of plant that are used in dried form they are high in nicotine and consequently addictive in nature. Tobacco can be taken in the forms of chewing, snuff and smoking. Tobacco use is one of the most important risk factors for oral diseases including periodontal diseases, oral mucosal lesions, oral ulcers and oral cancers. (Clichy, 2003)

By 2020 predicted that tobacco will become leading cause of death and disability. World wide more than 10 million people will be killed due to use of tobacco than deaths from aids, tuberculosis maternal mortality

and motor vehicle accidents. Till the year 2000 tobacco might have killed more than 60 million people in developed countries which is more than the number of people who have died in the word war II. (Mukesh Yadav, 2001)

Drug abuse is the use of illicit drug or misuse of legitimate drug resulting in the physical or psychological harm. It includes smoking ganja or cocaine or LSD, injecting morphine, drinking alcohol and so forth, there are sometimes referred to as being high on speed or trip or getting ticks. Over the counter drugs are those drugs with in the exception of tobacco and alcohol that can be purchased without a physician prescription. (Neeraja, 2006)

Most adolescents are able to experiment once or twice with different drugs such as marijuana, cocaine or alcohol and make the choice not to continue using these drugs or that they are not appropriate for their age. (Lippincott)

Adolescent abusing drug has often adopted the use of substances as a means of coping with feeling of depression, anxiety, restlessness or chronic feelings of boredom or emptiness.

The percentage of senior high school students who reported smoking in the past 30 days was approximately 45.2% for boys and 40.5% for girls. (Centers for Disease Control and Prevention, 1999)

Adolescents at greatest risk 80% to 90% of high school students who have tried alcohol or the 45% to 55% who have tried marijuana but rather the estimated 4% who report daily use of alcohol during the past 30 days and the 1% to 2% who use hard drugs regularly. **(**U.S Department of Health and Human Services, 1999)

Approximately 9.3% to15.8% of boys from 10 to 18 years old and from 3.8% to 9.2% of girls are affected conduct disorder. Conduct disorder was 3 to 4 times higher for boys than girls. (Loeber, et.al, 2000)

**NEED FOR THE STUDY**

Clay in the hands of a potter is mould into a beautiful form so are the children who are the responsibilities of the school teacher handled with love and care they become something beautiful or else they will be discarded or broken.

Children and adolescents have different problems in the areas of school, home among peers and teachers and also in general which need to be studied in depth. (Pandian, D.R, 1991)

School teachers can be sensitized to the need for positive mental health among adolescents because they cater to a large target population. This will provides quantum leap in the health promotion and preventive programmes.

Also considering the complications the complexities of mental health problems among adolescents integrated efforts of teacher, parents and mental health professional are indispensable. But effective handling of these problems requires additional skill and knowledge on the part of the teachers. At a national workshop on promotion of mental health held at Cochin, 1991. It was communicated that one of the components in achieving mental health is that, "Teacher must have adequate knowledge skill and attitude to foster better mental health in children".(Parthasarathy, R., 1994)

The social and behavior choices of today's teenagers predict the health of tomorrow's adult student spend considerable amount of their wakeful hours in schools with the teachers whose from time immemorial has been help up with great regard. This gives the teachers ample opportunity to recognize adolescents displaying maladaptive behavior. Also teachers by virtue of their stance can help adolescents tide over this period of turbulence to attain good and positive mental health.

Master S. Roshan, in the proceedings of the indo-us symposium conducted in October 1987 at Bangalore, suggested that for a meaningful mental health programmes, help from schools and college should be sought.

American College of Physician's Association, (1989) stated that active promotion of adolescent health and well being is required. This means that adolescence should be viewed as a critical stage of growth and development and not simply as a period of transition from childhood to adulthood.

Barg Butter and Franklin, (2004) conducted a study to assess the attendance problem and its outcome among 80 samples of 13-15 years old school children at Botswana. It was a survey approach with descriptive design. Results showed that the school children who failed to attend more than 40 % of a school term were conduct problem.

Rosario, (1998) conducted a study in Bangalore and found that 11.27% of school going adolescents boys and 1.47% of girls were psychologically disturbed. The rate of disturbances was highest in the age group of 13 and 14 years. It has been found that 20-50% of the adolescents in any set up suffer from different emotional problems that they are incapacitated both in the academic and extracurricular activities. The social and behavioural choices today's teenagers predict the health of tomorrow's adults.

The problems among adolescents have detrimental effect on their mental health and therefore needs special attention from the mental health professional. But the prevailing conditions can't afford to avail the above

ideal situation and hence it is necessary to plan alternative strategy to promote and maintain the psychological and social health of students.

Marmot ML, (1993) reported that regardless of physiological or emotional readiness the adolescent has expectations. Too often adolescents tend to develop a substance abuse as a means of coping with their difficulties to accomplish the developmental tasks.

Jonson S, (1994) reported that smoking is the primary preventable cause of death and yet 3000 adolescents become smokers each day most adult smokers begin this bad habit at the age of 18.

Deykin. N, (2001) reported that the transition in the early adolescent stage (physical, psychological and social) make then to be confused, lonely and depressed. When depression is prevalent it is a risk factor substance abuse in an adolescent. It not only affects the individuals but the entire family and society.

Global Youth Tobacco Survey, (2000-2004) reported nearly 5 million people die due to tobacco use every year. By the year 2020 the rate is likely to increase to 1o million tobaccos attributable deaths, among where seven million deaths will occur in the developing countries like mainly china and India.

India is the second largest producer of tobacco in the world. Every year 80,000-90,000 Indians die due to tobacco use. Most tobacco users start using tobacco before the age of 18 years WHO 1988 estimated that

20-30% in the 18-25age group in United States use cocaine and 1981 report stated that 3.1% adolescents used cannabis.

National center for health statistics stated that suicide is the third leading cause of death for teenagers aged15-19 years between the year 1980 and 1990. Suicide rates increased by 30% but have gradually decreased in 1985. The rate of suicide in the 15-19 years old population was 7.9 a decrease of 7% from 1990.

Approximately 4,00,000 people die annually because of tobacco used and an estimate 60% of the direct health care cost in the united states go to treat tobacco related illnesses. (Kaplo & Sadock, 2001)

Heroin is considered a highly addictive drug a CNS depressant. The estimated number of heroin users which remained fixed at roughly 6,00,000 from the 1970s into the 1990s almost quadrupled in the 1990s to an estimated 2.4million users. (Lamarine, 2004)

In Bhuvaneshwar with a population 2.3 lakhs the number of drug addicts were estimated as 20 % Kanpur is first emerging city of drug addiction. The study says out of its total adult male population of 5,90,291 in the age group of 15-60. There could be around 34,768 drug users 2007.

Adolescence is the period is more vulnerable to them because many physiological changes take place during that time. Today's

adolescents are the adults of tomorrow their health and knowledge the health of the complete generations.

Adolescents are more flexible in their attitude and have no social status to safeguard. Their health is directly linked to the behavior which is developed and modified with in the family and the environment.

Many adolescents are affected by mental health problems. Studies show that around one in five adolescents do pass through a more prolonged phase of emotional difficulties and one in 10 adolescents suffer mental illness severe enough to cause problems in their development and daily life.

The school teachers by joining forces with the mental health professionals can inflate the balloon of mental health services, essential to explore teachers knowledge and role perception towards promotion of mental health in schools, among adolescents.

Apart from this the investigator had come across very limited studies done to assess the teacher's knowledge on common behavioural problems of adolescent. Hence this study is selected.

**STATEMENT OF THE PROBLEM**

A STUDY TO ASSESS THE KNOWLEDGE OF HIGH SCHOOL TEACHERS REGARDING SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS IN A SELECTED HIGH SCHOOL AT SALEM DISTRICT.

## OBJECTIVES OF THE STUDY

1. To assess the knowledge of high school teachers regarding selected behavioural problems among adolescents.
2. To determine the relationship between the knowledge of school teachers on behavioural problems with selected demographic variables such as age, sex, educational qualification, teaching experience.
3. To prepare a health pamphlet regarding selected behavioural problems among adolescents.

## OPERATIONAL DEFINITION

### Knowledge

Knowledge is referred to the correct responses of school teachers on self administered knowledge questionnaire regarding selected behavioural problems as evident from the test score.

### High School Teachers

The school teachers include those teachers with professional qualifications who handle classes X, XI &XII standard in selected school.

### Adolescence

Referred to those who were at the age group of 15-19 years.

### Behavioural Problems

It affects the child behaviours, feeling, difficult to do well in school. The selected behavioural problems are conduct, emotional and substance abuse.

**Conduct Disorder**

Conduct disorders refers as the child will behave antisocially by breaking the other's property, fighting with others, truancy from school and home, fire setting, aggression toward people and animals.

**Emotional Disorder**

Emotional disorders refer as the children will feel for something fear about some objects and anxiety to the unwanted situations.

**Substance Abuse**

Substance abuse is like misuse of addicting substance like alcohol, nicotine, tobacco and use of illicit drugs that disturbs the normal physical, psychological, social and occupational functioning of an individual.

**ASSUMPTIONS**

1. Teachers will have less knowledge regarding selected behavioural problems of adolescents.
2. There will be a significant relationship between the knowledge score and the socio demographic variables such as age, sex, educational qualifications and teaching experience, participation in inservice education of teachers.

## LIMITATIONS

1. School teachers who are dealing with X, XI &XII standard student only included in the study.
2. Sample was limited to only 40 teachers in a selected school at Salem District. So the findings cannot be generalized.

## CONCEPTUAL FRAME WORK

A conceptual frame work is the precursor of a theory. It provides broad perception for nursing practice, research and education. Their overall purpose is to make scientific findings meaningful and generalizable.

Conceptual framework is the conceptual understanding of a study. It refers to the understanding of interest and reflects the assumptions and philosophical view of investigation. (Denise F.Polit, 2006)

According to Polit and Hungler, a conceptual frame work is interrelated concepts on abstractions that are assembled together in some rational scheme by virtue of their relevance to a common theme. It is a device that helps to stimulate research and the extension of knowledge by providing with direction and impetus.

The conceptual framework for the study is based on the "Modified Pender's health promotion model (1996)". According to the model, health promotion is defined as activities directed towards the development of resources that maintain or enhancing an individuals well

being. The model is divided into three major components like cognitive perceptual factor, modifying factor, participation in health promotion behavior.

**INDIVIDUAL PERCEPTION**

The individual perception , "The primary motivational mechanisms of health promoting behaviours" are said health exert a direct influence on health promoting behavior of all the cognitive perceptual factors, perceived control of health, perceived self efficacy and perceived health status are among strongest determinants of health promoting behaviours.(Frank Stromberg, et.al., 1990)

In the present study, the individual perceptions considered are inadequate knowledge on selected behavioural problems of adolescents such as conduct disorder, emotional disorder, substance abuse and perceived benefits such as acquiring adequate knowledge of school teachers regarding behavioural problems of adolescents.

**MODIFYING FACTORS**

Modifying factors consist of demographic characteristics, interpersonal influences, situational and behavioural factors.

Pender's states that according to the "Health Promotion Model" modifying factors exert their influence through the cognitive perceptual mechanisms that directly affect the behavior.

Modifying factors included in this study are teachers age, sex, educational qualification, teaching experience, participation in inservice education on child psychology, interpersonal influences like friends, colleagues and self learning, situational factor like place of school rural and urban, behavioural factor like knowledge on health, identification of behavioural problems among adolescents.

**PARTICIPATION IN HEALTH PROMOTION BEHAVIOUR**

Cognitive perceptual factors constitute the exclusive sources of all the connection between the modifying factors and participation in health promoting behaviours.

**CUES TO ACTION**

It is the last part of the health promotion model and consists of activating cues on triggers that spark of health promotion activity such a mass media, participation in inservice education, information from health care personnel, discussion with friends and colleagues about behavioural problems.

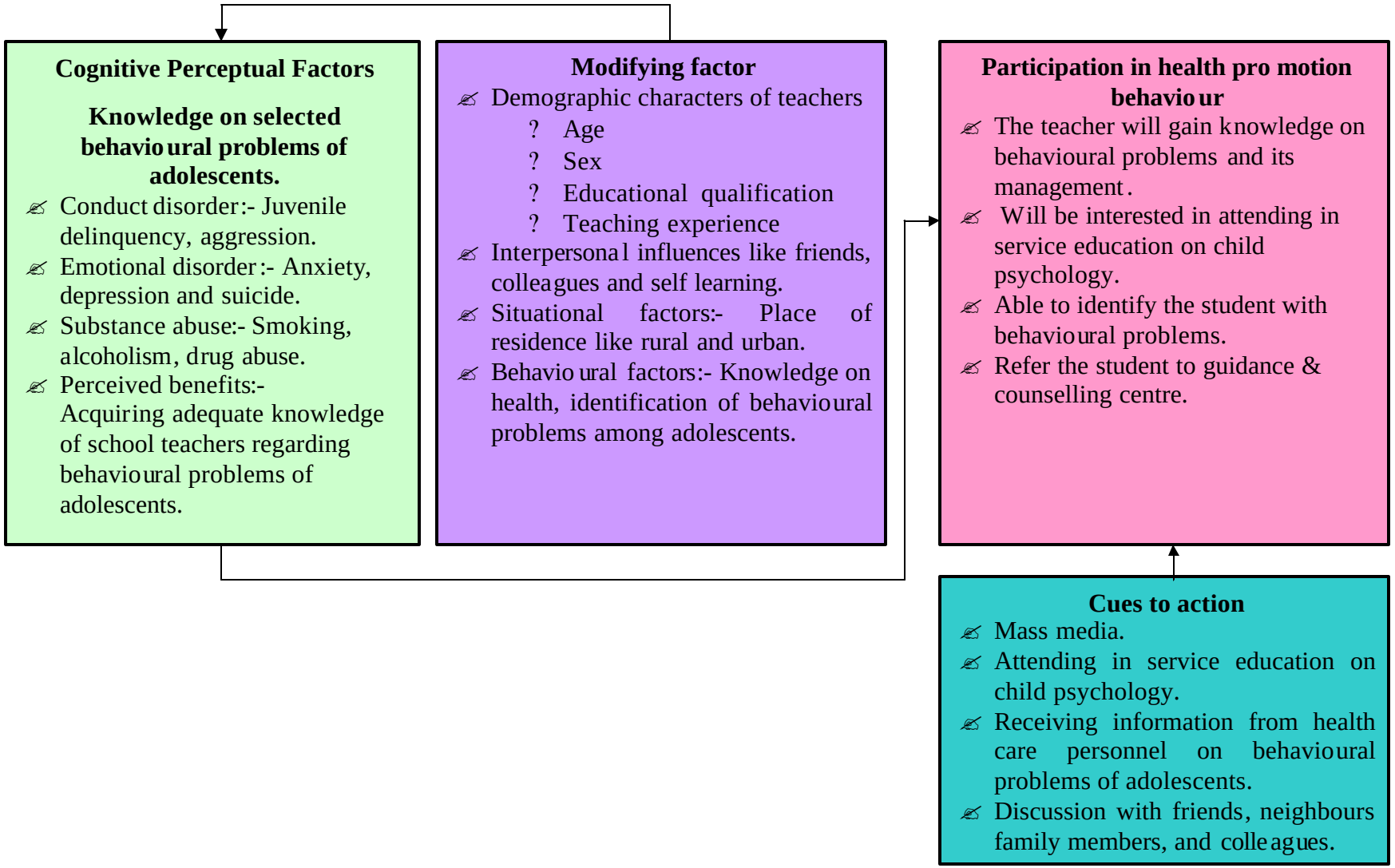



**FIG – 1.1: ADOPTED FROM MODIFIED PENDER'S HEALTH PROMOTION MODEL (1996)**

# CHAPTER-II

## REVIEW OF LITERATURE

A good research does not exist in vaccum. Research findings should be an extension of previous knowledge and theory as well as guide for research activity. In order for a researcher to build an existing work it is essential to understand what is already known about a topic. A thorough review of literature provides a foundation upon which to base new knowledge.

A literature review involves the systematic identification, location, scrutiny and summary of written material that contains information on research problem. (Polit and Hungler, 2006)

Review of literature is a broad systematic and critical collection and evaluation of important scholarly published literature as well as unpublished materials. The review serves as an evidence and essential background for any research. (B.T.Basavanthappa, 2004)

Review of literature is a critical summary of research on a topic of interest generally prepared to put a research problem in context to identify gaps and weaknesses in prior studies so as to justify a new investigation. (Polit and Beck, 2004)

Review of literature was done from published articles, textbooks and report, present study the investigator was reviewed and organized the related literature as the following section:

- ✍ **Literature related to adolescents and selected behavioural problems among adolescents.**
- ✍ **Studies related to selected behavioural problems among adolescents.**

## LITERATURE RELATED TOADOLESCENTS AND SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS

Adolescence is that it is a period between the ages of 10 and 15 years of bio-psychosocial maturation leading to functional independence in adult life. (Russell Viner, 1998)

Adolescence is the period of recapitulation of the childhood oedipal complex. (Freud)

Adolescence is a period of "stress and strain", "storm and strife". They are particularly prone to mental health problems because of the tension, frustration, confusion and feeling of insecurity. The common mental ailments are mood disorders like anxiety, depression, suicide, conduct disorder like violent and aggressive behaviours, these need timely identification and intervention. (A. Parthasarathy, 2007)

The struggle between identify and role confusion typified the adolescent stage of development (Erickson)

Adolescence as the second decade of life from 10 to 20 years of age but also defines a category of "youth" as being 10-25 years. In India there are more than 230 million adolescents which is approximately 23 % of the total population. Recent research indicate that 27% young people, 17-19 years have mental health problems involving anxiety, substance abuse disorder 15- 40% of adolescents suffers from anxiety and depression. (Osqgrave, 2000)

School teachers plays an important role in improving the academic performance of the child with psychological problems by modifying class room behavior. Positive reinforcement is a stimulus or event which increases the childhood of a response when it terminates or ends following response. (Prohbjot Malhi, 2002)

Teachers should be familiar with the basic principals governing mental health and applying them will result not only in great personal and professional satisfaction but also effective service to the budding human resources. (Bernard, W.H, 2000)

Behavioural problems in adolescents may be manifested as a disturbance in feelings eg. depression, anxiety, in behaviour eg. Conduct disorder/disturbances aggressive behavior in performance. Dysfunctions may involve any or all these areas. (Richer Dalton, 1997)

Behavioural problems are common in childhood. It is defined that a child has behavioural problems if behavior thoughts or feelings differ quantitatively from the norm and as a result of this difference, the child is either suffering or development is being significantly impaired. (David, 2000)

Behavioural problems are the reactions and clinical manifestations which are resulting due to emotional disturbances or environmental maladjustments. Conduct disorders is defined as repetitive, persistent, aggressive conduct in which basic rights are violated. (K.P. Neeraja, 2008)

Conduct or antisocial problem is not uncommon in the course of normal growth and development. Many children violate the rules and test limits to varying degree in their way to trust in their environment. (John Comely, 1994)

Conduct disorder as persistent, socially disapproved behavior that often involves damage to others property and aggression towards other people and is unresponsiveness to normal control or authority. (Robin, 1999)

Conduct disorder is defined as persistent antisocial behavior of children and adolescents that significantly impairs their ability to function in the social, academic or occupational area. (IAP, 2007)

The causes of conduct disorders include genetic factors, psychosocial factors like abused or neglected children, chaotic situations eg. angry disruptive , demanding unable to progress, Neuro psychological deficit and parental factors includes prenatal and perinatal complications, parental antisocial personality stress, poor parental practices. Family factors include broken family, large family size with lower socio-economic status. Social problems like poverty, unemployment, poor housing, organic factors like brain damage and neuro biological factors like decreased production of noradrenaline. (K.P.Neeraja)

Juvenile delinquent who breaks the law is a vagrant, persists in disobeying orders, whose behaviours endangers his own moral life as well as the moral life of other. (K.P. Neeraja, 2008)

Juvenile delinquency is a legal term for behavior of children and adolescents that in adults would be judged criminal under law.

Aggression is one of the negative outcomes that may emerge from general arousal and anger. (Kassinove and Tafrate, 2002)

Aggression is a behavior intended to threaten or injure the victim's security or self esteem. It means "to go against", "to assault" or "to attack." It is a response that aims at inflicting pain or injury on objects or persons. (Mary .C. Townsend, 2000)

Violent behavior may be associated with hormonal dysfunction caused cushing's disease or hyperthyroidism. (Tardiff, 2003)

Some research indicates that various neurotransmitters (eg. Epinephrine, norepinephrine, dopamine, acetylcholine & serotonin) may play a role in the facilitation and inhibition of aggressive impulses.

Most violent youth begin to exhibit their violent behaviours during early adolescence. More mild forms of aggression such as bullying which can involve verbal and physical aggression, peak during middle school years. The peak age of onset for serious violence is 15 to 16 years for boys and few years earlier for girls. (Nelson, 2006)

Emotional problems include grief, anxieties, anger and stress, rapid physical, psychological, social and sexual changes during adolescence may lead to stress. Strong emphasis placed on educational achievement has put a lot of pressure on adolescents. This could cause headaches, eyestrain difficulty in concentrating and sleep problems. (A.K.Dutta, 2007)

A change in student mood and behavior is a significant warning of possible suicide. The students become depressed and withdrawn and show disinterest in personal hygiene. These signs are followed by loss of interest in studies often he or she stops attending classes and stay at home most of the day. Usually the students communicate it to at least one or other person, usually in the form of a suicide warning. Depression is most common illness among adolescents which adversely affect mood, every interest, sleep, appetite and overall functioning. Studies have reported that

up to 80 % adolescents in the United States suffer from depression emerging early in life often recurs and continues into adulthood. There is evidence that another study done in Tobago also revealed that among 203 adolescents aged 14 -18 years,10% were having depressive disorder and 4.04% had major depression. (Dr MKC Nair and Ranjankumar Pejarer, 2001)

He revised during their adolescent health care visits that 28% of adolescents were seriously depressed and 12% reported having attempted suicide. (Riggs & Cheng's, 1998)

The signs &symptoms of major depression can be remembered using the mnemonic. SIGECAPS.

**S**- Sleep disturbance (usually decreased, can be increased

**I** - Interests decreased for usual activities

**G**- Guilt excessive or inappropriate

**E**- Energy decreased

**C**- Concentration problems.

**A** - Appetite change usually decreased can be increased

**P**- Pleasure decreased

**S** - Suicidal thoughts or actions

Depressed children and adolescents may not be able to identify their affective state. Depression can be indicated by "boredom", restlessness difficulty in concentrating, decreasing school performance,

preoccupation with somatic complaints (fatigue or vague or localized pains), running away, fights with peers and other "acting out behaviours".(Nelson, 2006)

Treatment of depression includes pharmacological approaches like antidepressants of various classes, the tricyclic antidepressants or serotonin reuptake inhibitors and nonpharmacological treatment includes individual psychotherapy or play therapies. (IAP, 2007)

Anxiety is a serious mood disorders which affects a person's ability to function in ever day activities. Anxiety is often a component found within many other mental disorders as well as the most common mental disorder that presents with anxiety and depression. Anxiety is the most common problem that occurs in adolescents. It is estimated that around 13% of young people had an anxiety in a year. (Samilama & Vijaya lakshmi, 2006)

Risk factors of anxiety include genetics, temperamental disposition for behavioural inhibition and social environment or life circumstances eg parental distress or dysfunction or trauma especially during vulnerable developmental periods eg. attachment or separation individuation.

Depression is estimated to affect 1% to 3% of school age children the rate increases upto 17% by late adolescence 20% to 50% of adolescents report significant, sub-syndromal levels of depression.(Hankin, 2006)

Suicide is an act of self destruction. Suicide is one of the commonest causes of death among young people. Suicide is the sixth leading cause of death among young people, aged 5-14 years and third leading cause of death among all those 15-24 years old. An alarming number of adolescents report thinking about suicide. In a national survey of high school students in 1995, 24% said that they had thought seriously about attempting suicide at some point,18 % indicating they had even made specific plans. A significant organic contribution plays a role in suicidal behaviour. It has been clearly established that victims of suicide have diminished CNS serotonin concentration as compared with nonsuicidal control dying under similar circumstances.(Christopher. H)

Health demands of young adulthood cannot be ignored since they form an important part of the human resource of our country. Habits and behaviours (food habits, substance abuse, conflict and emotional management, sexual expression) picked up during adolescence have lifelong impact. (Dutta, 2007)

Smoking is the inhalation of noxious fumes or irritating particulate matter that may cause severe pulmonary damage. Tobacco use often simply translated as cigarette smoking. Other forms include chewing and snorting tobacco, with other substances, using nicotine in the cigars are also called as smoking. (Michael H. Merson, 2001)

Smoke is a lung irritant a person must learn how to inhale and must adjust to the body's natural rejection of this substance. Once inhaled, the nicotine in tobacco is readily absorbed into the bloodstream and has an almost immediate effect on the reward systems in the brain. Nicotine mimics the neuron transmitter, acetyl chlorine receptors. Nicotine affects the brain in much the same way as cocaine, opiates and amphetamines. Nicotine not only stimulates the release of dopamine, it also prolongs the actions of dopamine by decreasing the metabolizing enzyme, monoamine oxidize and increases the expression of nitric oxide, which inhibits dopamine reuptake. So even more dopamine is available in the synapse.

All forms of cigarettes contain at least 10 mg of nicotine. By inhaling smoke the average smoker takes in 1 to 2 mg of nicotine with each cigarette. Most smokers among young adults use tobacco regularly because they are addicted to nicotine. Although nearly 35 million smokers make a serious attempt to quit each yotar, less than 7% who try to quit on their own stay abstinent for more than 1 year. (Lippinccott Williams, 2000)

Globally, 300 million young people 18-25 years smoke. Half of these who would smoke all their life are likely to die of tobacco related diseases. Others will suffer from tobacco related disease and requires extensive healthcare. The age at which smoking begins is becoming younger as 10 years old. The general population survey in India, reported

the use of tobacco or alcohol is 0.2 to 0.3% are children less than 15 years of age 2.5 to 3.4% are in the age group of 18-25 years. (Dutta, 2007)

Tobacco is dried leaves of the plant nicotiana tobaccum tobaccos which belongs to family Solana cae and was discovered by Columbus. Tobacco was originally a native plant of America but is now cultivated as cash crop throughout the world. The leaves are either smoked as cigarettes, beedi, pipes, cigars, snuffed or chewed as such in raw state or mixed with lime (khaini ) or with pan and various proprietary products like pan masala, guttcha. The women continue chewing tobacco due to habituation, to get relief from anxiety and appetite. (Mukesh Yadav, 2001)

Tobacco consumer has belief that tobacco consumption helps in relieving tooth ache and morning motions. Enjoyment 30.3% and curiosity 26.1% were the two major factors that make the consumption of tobacco amongst people. (Bartal. M, 2001)

Increasing tobacco consumption in the South East Asia region particularly among young women. Consumption levels range between 55% and 80% among adult men and between 3% and 71% among adult women. Millions of children, women and poorer section of our communities are addicted to tobacco. (Uton Muchtar Rafei, 1999)

The long term use of nicotine not only imposers a financial burden but also shortens the user's life. Among the long term effects are the

potential for respiratory diseases chronic bronchitis, emphysema, infections processes and cancer of the lung, larynx and or mouth , cancer of the esophagus, throat, kidney, pancreas and bladder and cardio vascular disease. (Marlow, 2003)

Pharmacologic therapies for cessation of smoking include nicotine replacement, antagonist therapy, aversive therapy, nicotine mimicking agents and non nicotine medication. Non pharmacologic therapies include sensory replacement and acupuncture. To remain abstinent many patients require counseling, psychotherapy and behavioural therapy. (Lippincott Williams, 2003)

Avoidance of tobacco use, proper oral hygiene by use of tooth paste and brush, intake of sugar free diet and drinking of fluorinated water are most important aspects to prevent dental carries due tobacco consumption. Mechanical removal of plaques and debris by proper brushing of teeth is effective. Dental examination and treatment must be undertaken promptly and regularly. (Achar's, 2000)

Alcohol is a substance commonly referred as ethyl alcohol. Alcohol is also known as ethanol and sometimes abbreviated as "ETOH". Alcohol containing beverages include bear, wine and distilled spirits. The alcohol content of a beverage is expressed as a proof is the concentration of ethyl alcohol. Alcoholism is the use of alcoholic beverages that causes any damage to the individual, society or both. (Marlow, 2006)

A definite cause of alcoholism hasn't been identified. Most experts believe genetic biological, psychological and socio cultural influences are involved. In genetic factors include identical twins have a higher risk than fraternal twins. Children of alcoholics have a fourfold increased risk of alcoholism. Other factors like biochemical abnormalities, nutritional deficiencies, endocrine imbalances, and allergic responses may contribute to alcoholism. Psychological factors include the urge to drink alcohol to reduce anxiety or symptom of mental illness, the desire to avoid responsibility in family social and low self esteem. (Lippincott Williams, 2004)

Alcohol can induce a general, nonselective, reversible depression of the CNS. About 20 % of a single dose of alcohol is absorbed directly and immediately into the blood stream through the stomach wall. Unlike other " foods" it does not have to be digested. The blood carries it directly to the brain where the alcohol acts on the brain's central control areas, slowing down or depressing brain activity. The 80 % of the alcohol in one drink is processed only slightly more slowly through the upper intestinal tract and into the blood stream. Only moments after alcohol is consumed, it can be found in all tissues, organs and secretions of the body. Rapidity of absorption is influenced by various factors. At low doses, alcohol produces relaxation, loss of inhibitions, lack of concentrations,

drowsiness, slurred speech, and sleep chronic abuse results in multi-system physiological impairments. (Mary. C. Townsend, 2000)

Acute or chronic abuse of alcohol (ethanol) is responsible for many acts of violence, suicide, accidental injury and death. Alcohol drinking is likely to begin in the middle school years, and increases with age. By 18 years of age 80 % to 90% of adolescents have tried alcohol. Ethanol is a depressant that reduces inhibitions against aggressive and sexual acting out. Severe physical and psychological symptoms accompany abrupt withdrawal, and long term use leads to slow tissue destruction, especially of the brain and liver cells. The most noticeable effects of alcohol occur within the central nervous system and include changes in cognitive and autonomic functions such as judgment, memory, learning ability and other intellectual capacities. (Marilyn. J. Hockenberry, 2009)

The chronic effects of alcoholism are also highly complicated. Chronic alcohol abuse may produce serious change to the bone marrow, heart, liver, pancreas, stomach, intestines, reproductive tract and neurological complications. Neurological complications include Korsakoff's syndrome and Wernicke's encephalopathy. Long term and excessive alcohol consumption is associated with an increase in the rates of certain cancers, particularly esophageal and colonic. The social and psychological effects of chronic alcohol abuse are wide spread and profound. They include job loss, family disintegration, homelessness,

depression, ill health, violence, accidents and multiple concomitant psychiatric disorders. (Lawrence. E. Frisch, 2006)

Alcohol intoxication symptoms include disinhibition of sexual or aggressive impulses, mood liability, impaired judgment and impaired social or occupational functioning, slurred speech, in co-ordination, unsteady gait, nystagmus and flushed face. Intoxication usually occurs at blood alcohol levels between 100 and 200 mg/dl. Death has been reported at levels ranging from 400- 700 mg/dl. (Mary.C.Townsend, 2006)

A heavy drinker who stops drinking or abruptly reduces his alcohol intake is likely to go through withdrawal. Symptoms begin shortly after the drinking stops and last for up to 10 days. Initially the patient experiences anorexia, nausea, anxiety, fever, insomnia, diaphoresis, agitation, tremor progressing to severe tremulousness and possibly, hallucinations and violent behavior. Major motor seizures (sometimes called "rum fits") may occur. (Lippincott William, 2004)

Diagnosis of alcoholism includes blood alcohol level of 0.10% weight/ volume (200mg/dl) indicates alcohol intoxication. Others include urine toxicology, serum electrolyte, blood urea nitrogen level, serum glucose level, plasma ammonia level, liver function studies, hematology studies, echocardiography and electrocardiograph also helps to evaluate alcoholism. (Lippincott, 2002)

Substance abuse as a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use of the substance. Substance abuse has also been referred to as any use of substances that poses significant hazards to health. (Mary. C. Townsend, 2000)

Substance abuse is a global phenomenon that involves adolescents and adults throughout the world with enormous physiological and psychological complications. The onset of tobacco, alcohol and other drug use generally occurs during adolescents. Many teenagers initially experiment with these substances and later become dependent.(Parthasarathy, 2007)

Substance abuse usually begins in adolescence. Few people begin misuse of tobacco after 18 years of age .Half of regular smokers who start in adolescence and smoke all their lives will eventually be killed by tobacco. Alcohol is the commonest factor in substance related deaths among the young adults. (Anupam Sachdeva, 2007)

Young people are often at the leading edge of social change and this is particularly true in the case of substance abuse. The surge in illicit drug usage during the last decade has been primarily a youth phenomenon, with onset of use most likely occurring during adolescent period. (Marlow, 2006)

Substances have deleterious effects over the individual. Substance abuse includes smoking, alcoholism and drug abuse. People will opt substance abuse for varied reasons like tensions release, salvation of problems, to fulfill their needs like to overcome anxiety, pressure or fatigue, experimental use, recreational use or circumstantial phase. As like smoking, and use of alcohol, drugs also abused by the young pleasure, peer pressure and for experiment. (Neeraja, 2007)

The treatment measures for drug addiction include building trust, provide basic living support, prevent or reduce negative behaviours and initiate a therapeutic process whenever the person is ready for it. Detoxification program, counseling and psychotherapy, pharmacotherapy, self help approach, continuing care and after care and ancillary health and services.

**STUDIES RELATED TO SELECTED BEHAVIOURAL PROBLEMS**

Bhasin. SK, et.al., (2010) conducted a study on depression, anxiety and stress among adolescent students belonging to affluent families. The main objectives of the study is depression, anxiety and stress (DAS) among adolescent school students belonging to affluent families and the factors associated with high level of (DAS).A total of 242 adolescents students belonging to class 9-12$^{th}$ selected for the study. The result shown that the scores in the three domains were found to be remarkably

correlated. It was seen that depression was significantly more among the females (mean rank 132.5) than the males (mean rank 113.2), p=0.03. Depression (p=0.025), anxiety (0.005) and stress (p<0.001) were all significantly higher among the board classes i.e $10^{th}$ &$12^{th}$ as compared to the classes 9th & $11^{th}$ all the three (DAS) were found to be have an inverse relationship with the academic performances of the students.

Schneeweiss. S, et.al., (2010) conducted a study to assess the risk of suicide attempts and suicides after initiation of antidepressant medication among children and adolescents. New users of antidepressants who were 10 to 18 years of age with a recorded diagnosis of depression. The findings of the study was 20,906 children who initiated antidepressant therapy 16,774 (80%) had no previous antidepressant use. During the first year of use 266 attempted and 3 completed suicide occur. Which yielded an event rate of 27.04 suicidal acts per 1000 person years.

Can. G, et.al., (2009) conducted a study to determine the factors contributing to regular smoking in adolescents in Turkey. The main objectives of the study to determine the levels of lifetime cigarette use, daily use, and current use among young people (aged 15-19 years) and to examine the risk factors contributing to regular smoking. A total of 4666 students participated in the study. The data were gathered by using the questionnaire method. The chi-square test and logistic regression analysis were used in data analysis. The result shows that male students smoked

3.02 time (95% CI2.20-4.16) more than females. Those whose mothers were smokers smoked 1.57 times (95% CI1.09-2.28) more than those whose mothers were not, those whose friends were smokers smoked 2.42 times (95%CI1.73-3.39) more than those friends were not smokers ,poor achievers in school smoked 2.62 times(95% CI1.97-3.49) more than high achievers. The risk rising 1.06 times 95% (11.01-1.11) with earlier age at first experimentation.

Johnson. JL, et.al., (2009) conducted a study to associations of trying to lose weight, weight control behaviours and current cigarette use among US high school students. The purpose of this study to describe the association of current cigarette use with specific healthy and unhealthy weight control practices among $9^{th}$-$12^{th}$ grade students. In this study youth risk behavior survey data (2005) were analyzed. Behaviours included current cigarette use trying to lose weight, and current use of 2 healthy and 3 unhealthy behaviours to lose weight or to keep from gaining weight, separate logistic regression models calculated adjusted odds ratio (AORs) for association of current cigarette use with trying to lose weight (model 1) and the 5 weight control behaviours, controlling for trying to lose weight (model 2). Result shows that in model 1 compared with students who were not trying to lose weight, students who were trying to lose weight had higher odds of current cigarette use (AOR-1.30,95CI:1.15-1.49) in model 2, the association of current cigarette use

with the 2 healthy weight control behaviours not statistically significant. Each of the 3 unhealthy weight control practices was significantly associated with current cigarette use with AORS for each behavior approximately 2 times as high among those who engaged in the behavior, compared with those who did not.

Montoya. R, et.al., (2009) conducted a study to estimate differences between perceived and reported drug use among university students in Colombia. The total 427 students aged 18 to 24 years are participated. The results suggest that students over estimate the use of tobacco, marijuana and cocaine over the last 12 months. Alcohol use was perceived accurately. Students who reported using those substances during that period overestimated their peer's drug use more than those who did not use.

Nyamathi. AM, et.al., (2009) conducted a study cross section study to correlates of heavy smoking among alcohol using methadone maintenance clients in LOS Angeles area. This study examines predictors of heavy smoking among 256 male and female methadone maintenance therapy (MMT) client from five MMT clinics. The findings of this study was women report lower rates of heavy smoking than men ( 47%Vs54%).

Park. HS, (2009) conducted a quasi-experimental study "to evaluate the effects of a core competency support program on depression and suicidal ideation for adolescents". Participants for the study were

high school students, 27 in the experimental group and 29 in the control group. Data were analyzed using the SPSS/WIN 14 program with X 12 test, t-test and ANCOVA. The study revealed that the participants in the core competency support program reported decreased depression scores and decreased suicidal ideation scores significantly different from those in the control group. The result of the study was core competency support program was effective in decreasing depression and suicidal ideation for adolescents.

Welte J.W, et.al, (2009) conducted a study to assess the association between problem gambling and conduct disorder among adolescents and young adults in United States. The purpose of this analysis is to examine the relationship between current problem gambling and current conduct disorder. Data were analyzed for a U.S national survey of respondents aged 14-21 years. The study results shows that a strong co-morbidity between current problem gambling and current disorder was found. Further analyses showed that early onset problem gamblers had a higher risk for conduct disorder than late onset problem gamblers.

Wang. KY, & Yang. CC, ( 2009) conducted a study to investigate the prevalence and predictors of smoking behaviour among military university students in Taiwan. Author was used cross-sectional design 2,477 students were recruited from 7 universities across Taiwan. Structured questionnaires were used to collect the data. The findings of

this study was the prevalence of smoking among students in Taiwan has been recently reported as 5.7% of this number 12.8% started smoking after enrollment in school and 33.3% became regular smokers.

William Andersen MK, et.al, (2009) conducted a study to examine the onset of alcohol consumption among children and adolescents at Danish. A total of 480 randomly chosen children and adolescents between 7 and 18 years of age. The study results suggest that age at onset of alcohol consumption was 13.4 years for boys and 13.9 yearsfor girls (p=0.020). There was a significant association between age at onset and smoking of the adolescents (hazard ratio 2.19, 95% confidence interval CI 1.16-4.12, p=0.015) and maternal smoking during pregnancy hazard ratio 2.231 95% CI1.31-3.78, p=0.003.

Bor. W, et.al., (2008) conducted a study to identify early risk factors for adolescents antisocial behavior. The total of 8000 participants. The findings of the study were based on a series of logistic regression models significant risk factors for adolescent antisocial behavior included children's prior problem behavior (i.e aggression and attention/ restlessness problems at age 5 years) and marital instability which doubled or tripled the odds of antisocial behavior.

Cao. H, et.al., (2008) conducted a study to examine the prevalence of emotional problems in Chinese children. The samples of 2,940 children aged 10 to 15 years were used. Child behaviour checklist and a

structured self rating questionnaire were administered. The result indicated that the 12.5 % of boys and 8.3 % girls have emotional problems.

Connor. DF, et.al., (2008) conducted a study to examine whether Quetiapine is superior to placebo in the treatment of adolescents with conduct disorder.9 youths were randomly assigned to receive Quetiapine & 10 youths were randomly assigned to receive placebo. Patients were assessed weekly throughout the trial. The study results shows that the Quetiapine was superior to placebo on all clinician. Assessed measures and on the parent assessed quality of life rating scale.

Gibbs. A, et.al., (2008) conducted a study to evaluate the impact of psychosocial interventions on children with disruptive and emotional disorders in a health camp. A total of 157 consecutively referred children with a range of emotional and behavioural problems were rated by parents and teachers before and after their residential stay, using the strengths and difficulties questionnaire. The study results shows significant improvements in SDQ related emotional, conduct, hyperactive and total problems.

Mastsuura, et.al., (2008) conducted a study to identify the children with conduct or antisocial problems which was investigated by using Rutter's questionnaire in Japan, China and Korea. The study sample were 2638 children from Japan 2432 children from China and 1975 children

from Korea. The prevalence rate of antisocial problem among children were 3.9 -12% in Japan, 8.3% in china & 14.1-19.1% in Korea.

Park. E, (2008) conducted a study to investigate the prevalence and risk factors of suicide attempt among adolescents in South Korea. The data of the 2006 youth health risk behavior web based survey collect by the Korean center for disease control was analyzed using logistic regression. The result shows that the prevalence of a suicide attempt was 5.2% in South Korea. The risk factors of a suicide attempt were suicidal ideation (31.83), depression (7.98), drug use (4.67), currently smoking (3.19), feeling unhappiness (2.77), stress (2.60), currently drinking alcohol (2.39), sexual activity (2.33), living with neither parent (2.24), initial alcohol drinking by age 9(1.80), health status (2.15), skipped breakfast (1.75), disease(1.65).

Young R. Sweeting, (2008) conducted a longitudinal study on alcohol use and antisocial behavior in young people among 2586 samples. The exploration of the causal effects of alcohol use or misuse and antisocial behaviour among young males, using a structural equation models of longer and shorter term relationships and joint effects models in respects of alcohol related trouble at age of above 15. The results shows there is support the susceptibility hypothesis, particularly in the longer term models. There in no support for pure disinhibition, antisocial behavior causing alcohol (mis) use reverse also applies.

Burke, (2007) conducted a study on in attention as a key predictor of tobacco use in adolescence in Pittsburgh. This study was chort study conducted among young adulthood. The results are no hyperactivity impulsivity, significantly predicted adolescent tobacco use and young adult daily uses the tobacco use and young adult daily uses the tobacco use and young adult daily uses the tobacco. Peer substance use, parental substance use and conduct disorder also predicted increases in tobacco use.

Castilla. R, et.al., (2007) conducted a study to compare gender symptoms of anxiety of the children who were exposed to the stress of current civil war Colombia. A total of 399 school children aged 15 were evaluated. Children and their parents were assessed with the screen for child anxiety related emotional disorder. The result indicates among 911 children, 93(54.71%) boys & 20(81.7%) girls had anxiety. The result reveals that the children who were exposed to dangerous and violent situation in their environment had experienced higher levels of anxiety symptoms which is particularly true of girls.

Check. K, et.al., (2007) conducted a cross sectional study estimate the over all prevalence of emotional and behavioural deviance among the school children in Johor Bhahau. Totally 589 children aged 10 - 12 years were investigated through parental scales. The result indicates 40%

children from rural area and 30.2% children from urban area have prevalence of emotional problems.

Maltena. G, et.al., ( 2007) conducted a study to investigate the behavioural and emotional problems in children with intellectual disability who are attending special schools in cape town, South Africa. The samples of 355 children were used. A prevalence of 31% of psychopathology was found through Rutter's questionnaire.

Monuteaux, MC., et.al, (2007) conducted a longitudinal study on predictors, clinical characteristics and outcome of conduct disorder in girls with attention deficit hyperactivity disorder.5 year prospective longitudinal study of girls with (n=140) and without (n=122)ADHD aged 6-18years. The result shows that the ADHD was significant risk factors for lifetime CD throughout childhood and adolescence. Among ADHD girls, childhood onset (<12 years) CD was predicted by parental antisocial personality disorder (ASPD), while adolescent onset CD (12 years) was predicted by family conflict.

Sangamesh Nidagundi, (2007) conducted a descriptive study to assess the knowledge of adolescents aged 16 and 19 years regarding substance abuse among 100 students in Karnataka. The results of the study was found that41.28%meanknowledgescoreforboysand39.46% mean score for girls.

Thomas. A, (2007) conducted a cohort study to describe the national trends in lung cancer incidence among young adults and the relationship to adolescent smoking. The result showed the lung cancer incidence rate among women aged 40-44 in Norway continued to increase into the most recent time inter 2005-2006, whereas the rate among men and aged 40-44 was essentially constant after 2005. Consequently lung cancer incidence rates converged among male and female young adults. Lung cancer incidence rates at age 40-44 were highly correlated with smoking prevalence at age 15-19 in males (r=0.88) and females(r = 0.82) within the same birth cohort. The lung cancer incidence rate in young Norwegian women now equals that of men. The risk of at age 40-44 was closely associated with teenage smoking, indicating that duration and age of onset is important.

Everett. SA, et.al., (2006) conducted a study to investigate the students perception of emotional problem is American public schools. Totally 726 public school students from 15-18 years were participated. Each student completed a self administered survey instrument under the supervision of teacher. The result indicates that 7% of girls and 14 % of boys had the emotional problems.

Niemela. SM, (2006) conducted a study to assess the association between drunkenness frequency and adaptive functioning at turkey, about 2306 adolescents boys with 18 years old were investigated. Self report

questionnaire were used to study the demographic factors adaptive functioning, risk behavior, life events and mental health service use. The result reveals that 85% reported as drunkenness and most of the subjects were occasionally drunk. Out of 85% of drunkenness 40% reported drunkenness less than a month and 35% reported drunkenness at a duration of less than once a week, while 10% reported being frequently drunk once a week. They concluded that occasional drunkenness is a normative alcohol use pattern and associates with social competence and good psychosocial functioning.

Sirvant Ruiz, (2006) conducted a study on factors related to young people's attitudes to the consumption of alcohol and other psychoactive substances among 775 young people. The results obtained confirm the multicominal nature of these phenomena. The attitudes of young people towards substance use was found to be more favourable the lower the perception of risk, the more mistaken their beliefs and more permissive their disposition to the use of alcohol and other illegal drug. Other determining factors are their relationship with per groups that use drugs, antisocial behaviours and attention seeking indications.

## SUMMARY

This chapter views about the literature review, literature related to behavioural problems such as conduct disorders, emotional disorder, substance abuse and studies related to conduct disorders, emotional disorder, substance abuse.

# CHAPTER-III

## METHODOLOGY

### INTRODUCTION

Methodology is a guide by the research to answer questions or test hypothesis. (Paul T.Lasard, 2004)

Research methodology involves systemic procedure in which the researcher starts from identification of problems to its final conclusion. It is a way to solve the research problems systematically. (Polit and Hungler, 2004)

A systematic method of spinning the problem of a research is known as research methodology. (Sanjay Narula , 2007)

Research methods may be understood as all those methods and technique that are used for research conduction. Thus research techniques and methods signify to the researchers use in performing research operations. (Nancy Burns, 2004)

Selection of an appropriate design makes the researcher to address critical issue to ensure that, the data produced by credible and interpretable within the chosen perspective research design refers to the researcher's overall plan for obtaining answers to the research questioning.

This chapter deals with the methodological approach and it is a wave to solve the research problem systematically. It includes,

- ✍ Research approach
- ✍ Research design
- ✍ Study setting
- ✍ Target population
- ✍ Sample
- ✍ Sampling technique
- ✍ Sample selection criteria
- ✍ Selection and development of instrument
- ✍ Content validity and reliability
- ✍ Pilot study
- ✍ Data collection procedure
- ✍ Plan for data analysis.

**RESEARCH APPROACH**

The research approach tells the researcher from where the data is to be collected, what to collect and how to collect it and how to analyze them. It also suggests possible conclusion and helps the researcher answering specific research questions in the most accurate and efficient way. (B.T Basavanthappa, 2008)

The research approach adopted for this study is non-experimental in nature. Surveys also collect information on people's knowledge, opinion, values and attitudes.

This study aims at assessing the knowledge of high school teachers regarding selected behavioural problems among adolescents.

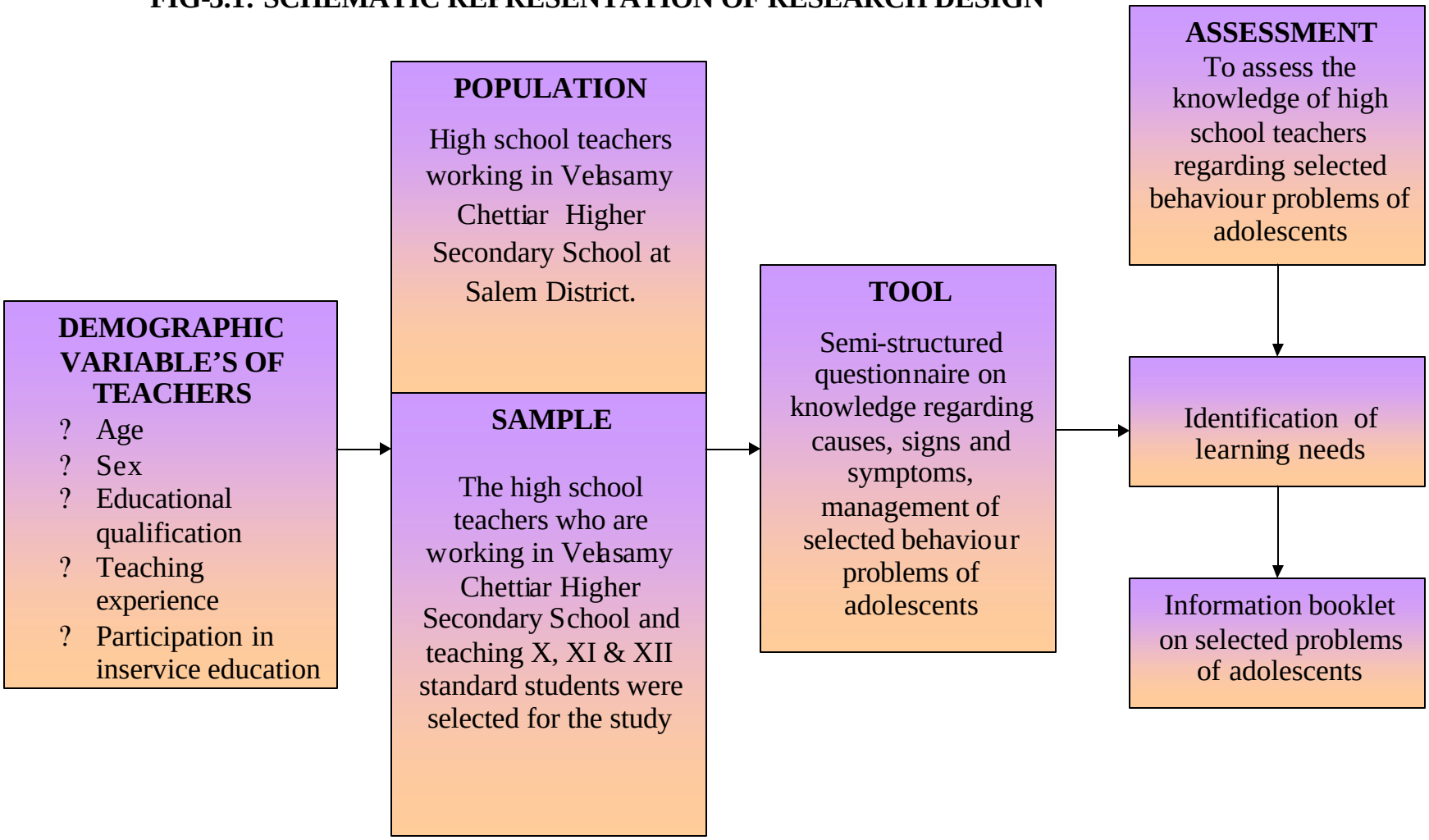
**RESEARCH DESIGN**

Research design is a blueprint for conducting a study that maximizes control over factors that could interfere with the validity of the findings. (Nancy Burns, 2005)

The term research design refers to the plan of scientific investigations. Research design designates the logical manner in which individuals or other units are compared and analyzed; it is the basis for making interpretations from the data. (Arvindkumar, 2005)

Research design is the overall plan for addressing a research question including specification for enhancing the study's integrity. Research design selected for this study was non-experimental descriptive research design with the objectives of assessing the knowledge of high school teachers regarding selected behavioural problems among adolescents.

**FIG-3.1: SCHEMATIC REPRESENTATION OF RESEARCH DESIGN**



## STUDY SETTING

Study setting is the physical location and condition in which data collection takes place. (Polit and Hungler, 2004)

Selection of the area for the study is one of the essential steps in the research process. The selection of the school for the present study is on the basis of

- Availability of subjects
- Feasibility of conducting the study
- Economic of time and money.

The present study was conducted in a Velasamy Chettiar Higher Secondary School at Omalur, Salem District. The study conducted for 40 selected samples of high school teachers. Totally 95 teachers were working in this school.

## POPULATION

Population is defined as the entire aggregation of cases that meet a designated set of criteria. (Polit and Hungler, 2004)

A population is a well defined set that has certain specific properties. (B.T.Basavanthappa, 2006)

The target population for the present study was teachers teaching X, XI &XII standard students in Velasamy Chettiar Higher Secondary School at Omalur, Salem District.

## SAMPLE AND SAMPLING TECHNIQUE

The sample is a subset of a population selected to participate in the research study. (Nancy Burns, 2004)

The sampling technique is the process of selecting a portion of the population to represent the entire population. (Polit & Beck, 2005)

The sample of this study is composed of 40 high school teachers of Velasamy Chettiar Higher Secondary School and teaching X, XI & XII standard students only.

Convenience sampling technique is used to select the 40 subjects from the target population. The investigator conducted a survey in the school to find out the total number of teachers who are teaching X, XI & XII standard students.

Convenience sampling is a selection of the most readily available Person's as participants in a study.

## CRITERIA FOR SELECTION OF SAMPLE

**Inclusion Criteria :**

- ✍ Teachers teaching the students from X, XI & XII standard.
- ✍ Teachers who gave consent for the study.

**Exclusion Criteria :**

- ✍ Teachers who are not teaching the students from X, XI & XII standard.
- ✍ Teachers who are unwilling to participate in the study.

## SELECTION AND DEVELOPMENT OF THE INSTRUMENT

## SELECTION OF TOOL

The instrument selected for the study was a vehicle that would obtain best data to draw conclusions pertinent to the study. (Treece & Treece, 2004)

Semi structured questionnaire is prepared to assess the knowledge of high school teachers regarding selected behavioural problems of adolescents.

Semi structured questionnaire is considered to be the most appropriate instrument to elicit the responses from the subjects.

## DEVELOPMENT OF THE TOOL

Steps in the construction of the tool the following steps were carried out in preparing the tool such as literature reviewed expert opinion. This helped in the selection of the content for the development of the tool.

## DESCRIPTION OF THE TOOL

The semi structured questionnaire was organized in two parts; part A and part B

### Part-A

Part A consists of socio-demographic variables of teachers. This part consist of questions including age, sex, educational qualification, teaching experience, participation in inservice education programme

on child psychology and teachers understanding about behavioural problems among adolescents.

**Part –B**

This part consists of questions related to knowledge of high school teachers regarding selected behavioural problems of adolescents. Totally 52 questions and these distributed in 3 sections and total score for this section was 216.

**Section-I**

It consists of totally 14 items related to knowledge of teachers about conduct disorders such as juvenile delinquency, aggression. Total score for this section was 58.

**Section –II**

It consists of totally 20 items related to knowledge of teachers regarding emotional disorder such as anxiety, depression, suicide. Total score for this section was 85.

**Section –III**

It consists of totally 18 items related to knowledge of teachers regarding substance abuse such as smoking, alcoholism, drug abuse. Total score for this section was 73.

Based on the scores the knowledge of teachers was divided into three categories

Below average -below 50% score

Average - 50 to70% score

Excellent - above 70% score

**CONTENT VALIDITY**

Content validity is concerned with the scope or range of items used to measure the variables. (Rose Marie Nieswaiadomy, 1993)

Validity is the most important simple methodological criteria for evaluating any measuring instrument. Validity refers to whether a measurement instrument is accurately measures what it is supposed to measure.

The experts in the field of pediatric nursing, psychiatric nursing and medicine examined the relevancy and accuracy of the items. Based on the expert's opinion, items regarding the knowledge of teachers related to conduct disorders were simplified. Finally the tool had 62 questions.

**RELIABILITY**

Reliability of research instrument is defined as the extent to which the instrument yields the same results on repeated measures. (Polit & Hungler, 2004)

The semi-structured questionnaire was tried out with 10 teachers. The spearman Brown's split half method was used to estimate the

reliability co-efficient and it found to be r=0.93, which indicates high reliability.

**PILOT STUDY**

Pilot study is a small scale version or trial run for the major study. (Polit & Hungler, 2004)

The function of this pilot study is to obtain information for improving the project for assessing its feasibility.

After obtaining permission from the principal a pilot study was conducted in Government Higher Secondary School, Ulagappampalayam in month of July 2010. 10 teachers were selected for the pilot study and administered semi-structured questionnaire. The teachers were co-operated well and answered for all the questions.

**DATA COLLECTION PROCEDURE**

The data was collected during the month of November 2010 at Omalur, Salem District.

The investigator personally visited the school and teachers were selected based on the inclusive criteria. The purpose of questionnaire was explained to the samples with self-introduction. The questionnaire was distributed to the teachers in their own classes and they took 25-30 minutes to fill the answers for the questions and they were very cooperative.

## PLAN FOR DATA ANALYSIS

Data obtained were analyzed view of objectives of the study by using descriptive and inferential statistics. The plan for data analysis was as follows.

- ✍ Data were organized in master sheet.
- ✍ The frequencies and percentage of the analysis of socio-demographic variables like age, sex, educational qualification, teaching experience, participation in inservice education programme on child psychology were analyzed and were presented in tables and diagrams.
- ✍ Mean score, standard deviation, range and mean score percentage for knowledge score on each behavioural problem among adolescents in different areas such as conduct disorder, emotional disorder, substance abuse and were analyzed and presented in tables.
- ✍ Inferential statistics especially Chi-square test is used to assess the relationship between the knowledge of teachers regarding selected behavioural problems of adolescents and demographic variables. The findings are expressed in tables, figures and graphs.

## CONCLUSION

This chapter deals with research approach, research design, study setting, sample and sampling techniques, development and description of the tool, content validity and reliability , pilot study, data collection procedure and plan for data analysis.

# CHAPTER-IV

## DATA ANALYSIS, INTERPRETATION AND DISCUSSION

This chapter deals with the analysis and interpretation of the data collected from forty teachers regarding their knowledge about the behavioural problems among adolescents. Data analysis is a method for rendering quantitative meaningful and intelligible information. **(**Polit and Hungler, 2006)

The data collected through semi-structured questionnaire were analyzed by using descriptive and inferential statistics which are necessary to provide a substantive summary of results in relation to the objectives.

**OBJECTIVES ARE**

1. To assess the knowledge of high school teacher regarding selected behavioural problems among adolescents.
2. To determine the relationship between the knowledge of high school teachers on behavioural problems with selected demographic variables such as age, sex, educational qualification, teaching experience.

## PRESENTATION OF DATA

The data is analyzed and presented in 3 sections,

**Section-I:**

Description of socio-demographic variables of high school teachers in frequencies and percentage analysis.

**Section-II:**

Descriptive analysis of the knowledge of teachers regarding general information, causes, signs and symptoms and management of conduct disorder, emotional disorder and substance abuse among adolescents carried out through the application of mean, standard deviation and mean percentage.

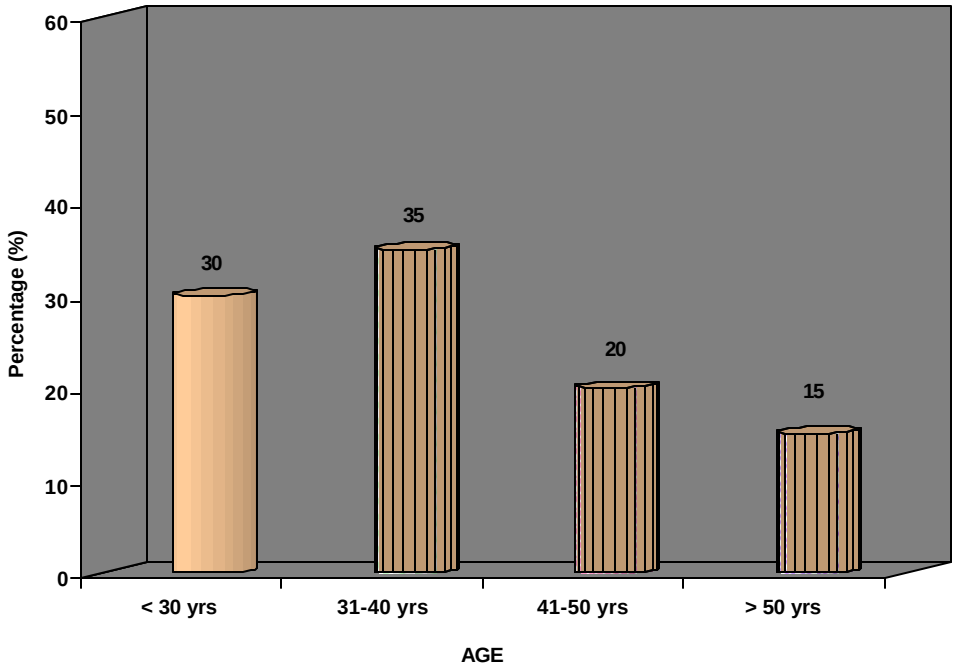
**Section-III:**

Association of selected socio-demographic variables with level of knowledge on behavioural problems among adolescents analyzed through chi-square test.

## SECTION – I

**Table & Figure - 4.1.1: Distribution of high school teachers by their age**

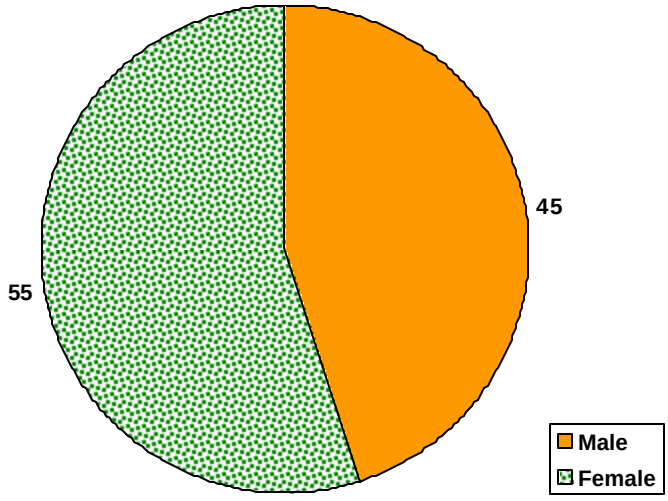
| S. No | Age | No (40) | Percentage % (100) |
|---|---|---|---|
| 1 | <30 years | 12 | 30 |
| 2 | 31-40 years | 14 | 35 |
| 3 | 41-50 years | 8 | 20 |
| 4 | >50years | 6 | 15 |
| | **Total** | **40** | **100** |




Among 40 teachers, the maximum numbers of teachers 14(35%) from 31-40 years and12(30%)were below 30 years and 8(20%) were from 41-50 years and 6(15%) were from above 50 years.

**Table & Figure - 4.1.2: Distribution of high school teachers by their sex**

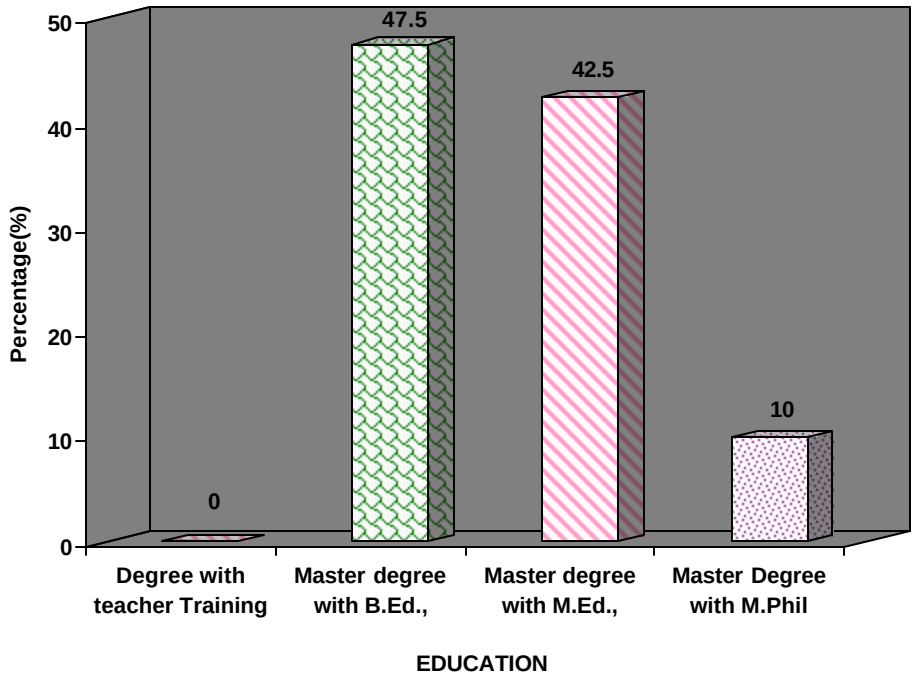
| S. No | Sex | No(40) | Percentage % (100) |
|---|---|---|---|
| 1 | Male | 18 | 45 |
| 2 | Female | 22 | 55 |
| | **Total** | **40** | **100** |




Out of 40 teachers 18(45%) were male teachers and 22(55%) were female teachers.

**Table & Figure-4.1.3: Distribution of high school teachers by their education.**

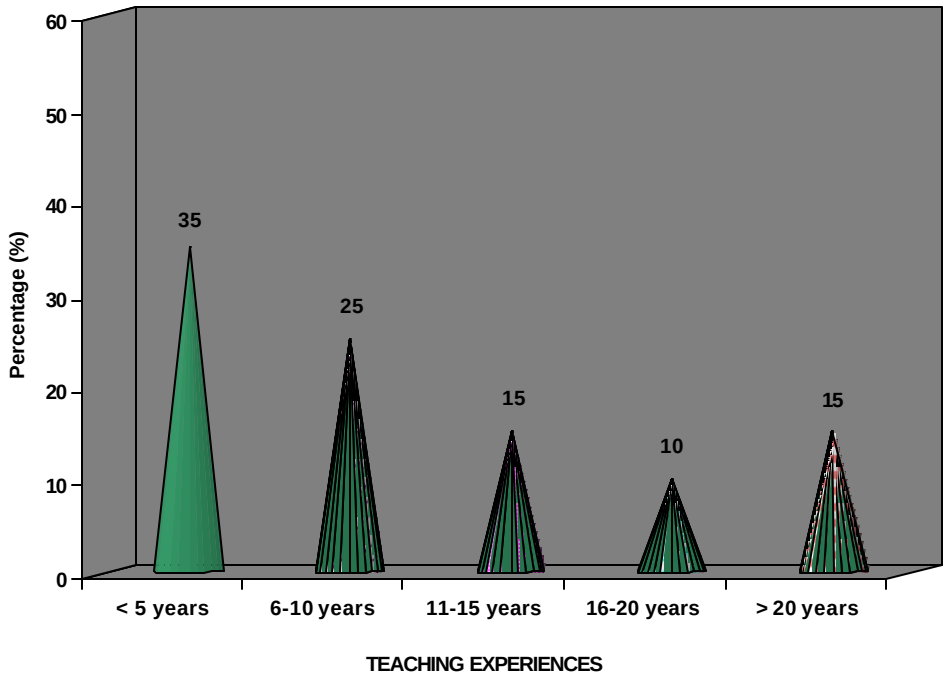
| S. No | Education | No (40) | Percentage % (100) |
|---|---|---|---|
| 1 | Degree with teacher training | 0 | 0 |
| 2 | Master degree with B.Ed | 19 | 47.5 |
| 3 | Master degree with M.Ed | 17 | 42.5 |
| 4. | Master degree with M.Phil | 4 | 10 |
| | **Total** | **40** | **100** |




Out of 40 teachers 19(47.5%) of have master degree with B.Ed and 17(42.5%) had master degree with M.Ed and 4(10%) had master degree with M.Phil.

**Table & Figure -4.1.4: Distribution of high school teachers by year of teaching experience.**

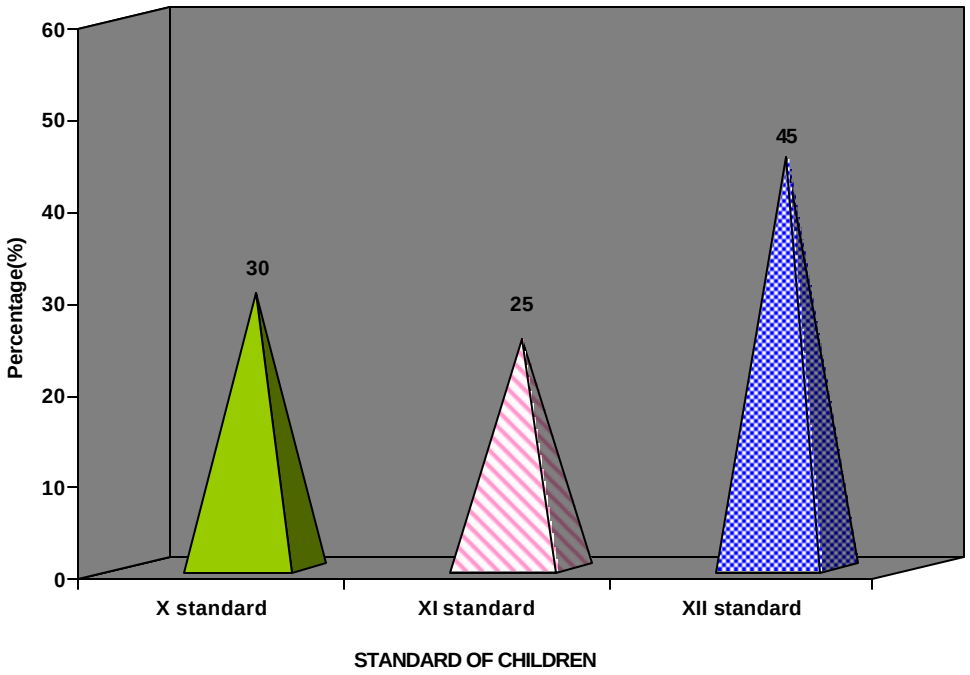
| S. No | Teaching experience | No(40) | Percentage % (100) |
|---|---|---|---|
| 1 | <5 years | 14 | 35 |
| 2 | 6-10 years | 10 | 25 |
| 3 | 11-15 years | 6 | 15 |
| 4 | 16-20 years | 4 | 10 |
| 5 | >20years | 6 | 15 |
| | **Total** | **40** | **100** |




Out of 40 teachers 14(35%) had below 5years of experience, 10(25%) had 6-10 years of experience, 6(15%) between 11-15 years of experience and the rest 4(10%) had 16-20 years of experience, 6(15%) had above20 years of experience.

**Table & Figure -4.1.5: Distribution of high school teachers based on their dealings with which standard of children.**

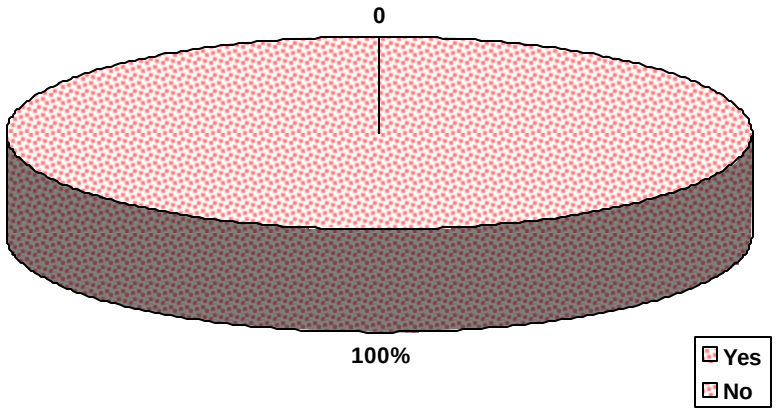
| S. No | Standard of children | No (40) | Percentage % (100) |
|---|---|---|---|
| 1 | X standard | 12 | 30 |
| 2 | XI standard | 10 | 25 |
| 3 | XII standard | 18 | 45 |
| | **Total** | **40** | **100** |




Out of 40 teachers 12(30%) of them dealings X standard children,10(25%) of them dealings XI standard children, 18(45%) of them dealings XII standard children.

**Table & Figure -4.1.6: Distribution of high school teachers who had child psychology in their curriculum.**

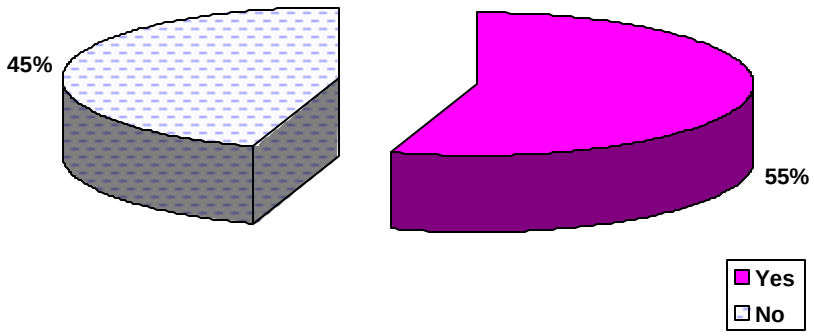
| S. No | Child Psychology | No (40) | Percentage % (100) |
|---|---|---|---|
| 1 | Yes | 40 | 100 |
| 2 | No | 0 | 0 |
| | **Total** | **40** | **100** |




All 40(100%) teachers have studied child psychology in their curriculum.

**Table & Figure-4.1.7: Distribution of high school teachers who had inservice education on child psychology.**

| S. No | Inservice education | No (40) | Percentage % (100) |
|---|---|---|---|
| 1 | Yes | 22 | 55 |
| 2 | No | 18 | 45 |
| | **Total** | **40** | **100** |




More than half 22(55%) teachers had inservice training regarding child psychology and 18(45%) did not have inservice training regarding child psychology.

## SECTION-II

### Assessing Knowledge on Behavioural Problems.

**Table & Figure - 4.2.1: Knowledge of high school teachers on selected behavioural problems among adolescents.**

| S. No | Behavioural Problems | Maximum Score | Range | Mean | SD | Mean Score |
|---|---|---|---|---|---|---|
| 1 | Conduct disorders | 58 | 19-37 | 21.17 | 2.94 | 37.14 |
| 2 | Emotional disorders | 85 | 21-48 | 27.82 | 5.29 | 32.73 |
| 3 | Substance abuse | 73 | 19-46 | 24.65 | 5.2 | 33.76 |
| | **Over all Total** | **216** | **59-131** | **73.64** | **13.43** | **34.09** |

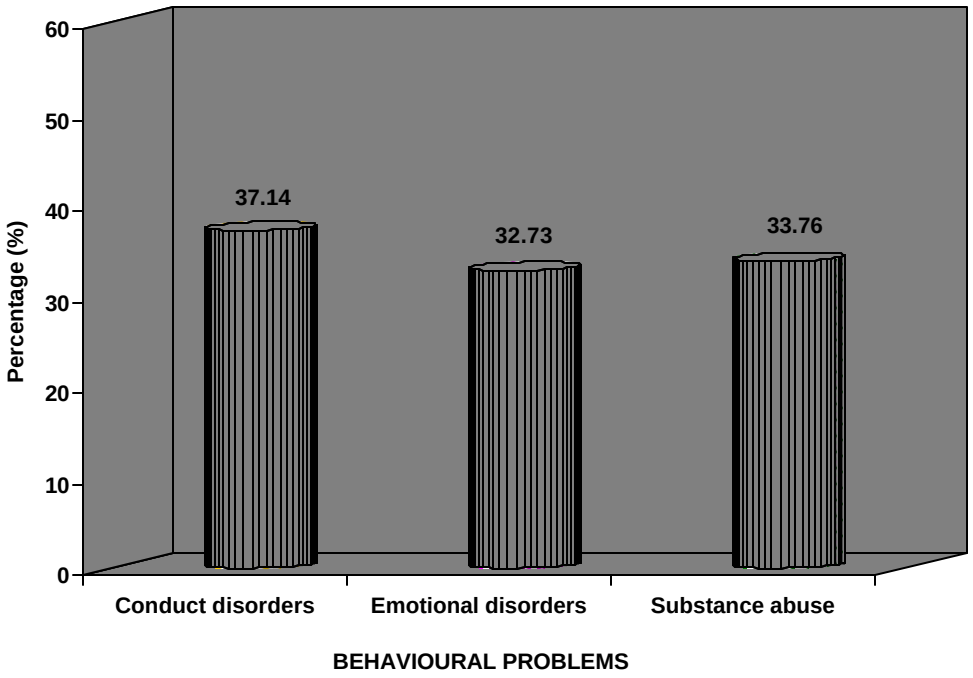


Table and figure 4.2.1 presents the knowledge score of teachers. The mean score percentage of knowledge regarding conduct disorder is 37.14 %, emotional disorder is 32.73% and substance abuse is 33.76%. The overall knowledge on behavioural problem through mean score percentage is 34.09 %only. This shows knowledge of teachers regarding behavioural problems among adolescents are below average.

All the selected teachers were studied the subject child psychology in their curriculum. But the overall knowledge of the teachers on behavioural problems were below average. Therefore, the investigator felt that there was no significant correlation between their knowledge level and their curriculum on child psychology.

**Table & Figure-4.2.2: Distribution of teachers according to their knowledge regarding conduct disorder.**

| S. No | Areas | Mean | SD | Mean score% |
|---|---|---|---|---|
| 1 | General information | 7.03 | 3.06 | 39.05 |
| 2 | Causes | 7.55 | 3.53 | 37.75 |
| 3 | Signs & symptoms | 2.8 | 1.38 | 35 |
| 4 | Management | 3.8 | 1.43 | 34.54 |

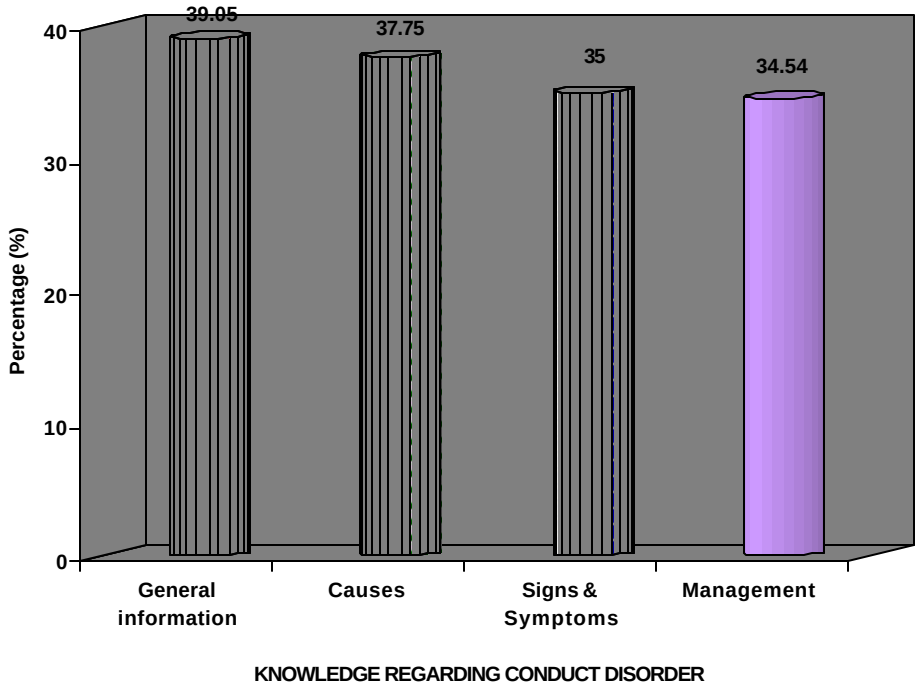



Table and figure 4.2.2 presents the knowledge score of teachers regarding conduct disorder in different areas such as general information, causes, signs and symptoms and management. The mean score percentage of teacher's knowledge regarding conduct disorder in the area of general information 39.05%,causes 37.75%, signs and symptoms 35%,management 34.54%.

**Table & Figure-4.2.3: Distribution of teachers according to their knowledge regarding emotional disorder.**

| S. No | Areas | Mean | SD | Mean score% |
|---|---|---|---|---|
| 1 | General information | 7.55 | 3.54 | 29.03 |
| 2 | Causes | 8.1 | 3.58 | 32.4 |
| 3 | Signs & symptoms | 7.68 | 2.69 | 34.90 |
| 4 | Management | 4.5 | 0.94 | 27.5 |

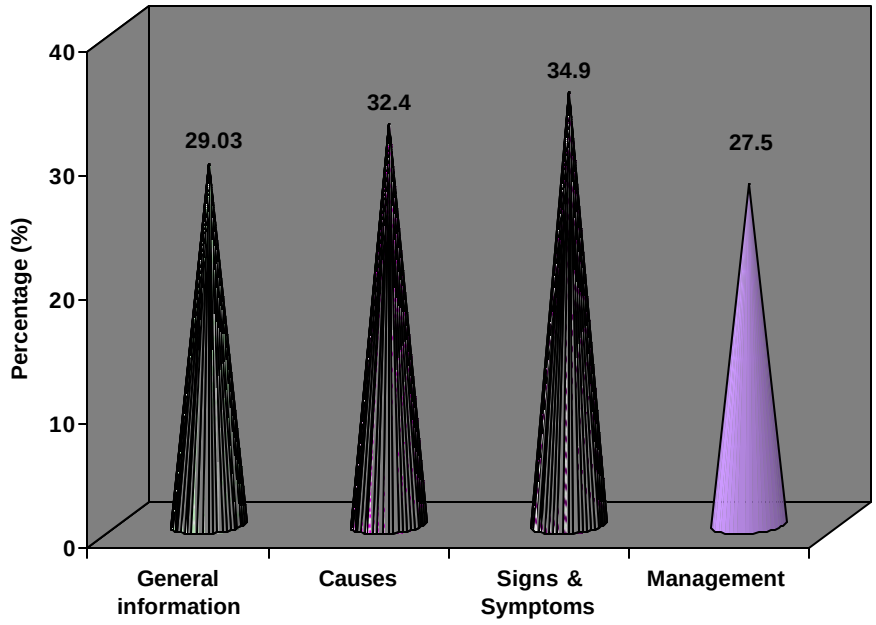



Table and figure 4.2.3 shows the knowledge score of teachers regarding emotional disorders in different area, such as general information, causes, signs and symptoms and management. This shows the mean score percentage of knowledge on emotional disorders in the area of general information 29.03 , causes32.4% ,Signs and symptoms 34.90%, management 27.5%.

**Table & Figure -4.2.4: Distribution of teachers according to their knowledge regarding substance abuse**

| S. No | Areas | Mean | SD | Mean score% |
|---|---|---|---|---|
| 1 | General information | 6.17 | 2.30 | 38.56 |
| 2 | Causes | 7.45 | 2.88 | 41.38 |
| 3 | Signs & symptoms | 5.8 | 2.69 | 23.20 |
| 4 | Management | 5.22 | 2.58 | 37.28 |

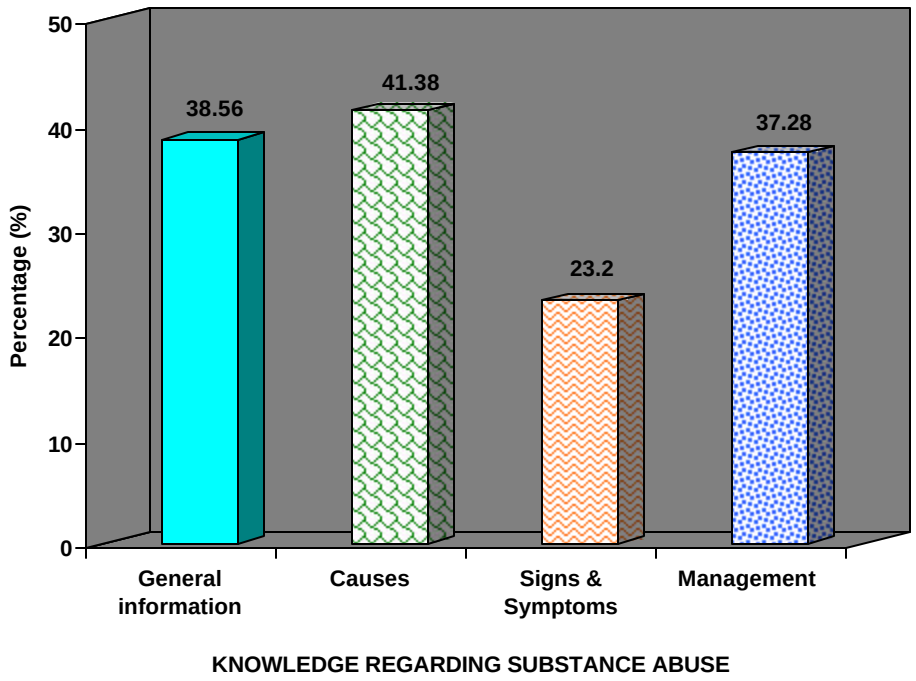



Table and figure 4.2.4 represents the knowledge score of teachers regarding substance abuse in different areas such as general information, causes, signs and symptoms, management. This shows the mean score of teachers knowledge on substance abuse in the areas of general information is 38.56%, causes is 41.38% signs and symptoms is 23.20% and management is 37.28%.

## SECTION-III

## ASSOCIATION OF SELECTED SOCIO DEMOGRAPHIC VARIABLES WITH LEVEL OF KNOWLEDGE

**Table 4.3.1: Association between the knowledge on behavioural problems with age of high school teachers.**

| S. No | Age | T. No (40) | Knowledge score | | | | Chi-square |
|---|---|---|---|---|---|---|---|
| | | | < Average | | >Average | | |
| | | | No | % | No | % | |
| 1 | < 40years | 26 | 17 | 77.27 | 9 | 50 | 4.01* |
| 2 | >40 years | 14 | 5 | 22.73 | 9 | 50 | |

'*' - Significant at 5% level; ($?^2$ = 0.05; df = 1; table value =3.84)

The above table 4.3.1 displays the statistical outcomes of chi-square analysis. It was worked out the statistical significance of association between the knowledge on behavioural problems and age of the high school teachers. The chi-square test shows that there is a significant association of knowledge and age of the high school teachers.

**Table-4.3.2: Association between the knowledge on behavioural problems and sex of high school teachers.**

| S. No | Sex | T. No (40) | Knowledge score | | | | Chi-square |
|---|---|---|---|---|---|---|---|
| | | | < Average | | > Average | | |
| | | | No | % | No | % | |
| 1 | Male | 18 | 12 | 54.55 | 6 | 33.33 | $1.6^{NS}$ |
| 2 | Female | 22 | 10 | 45.45 | 12 | 66.67 | |

'NS'- Not significant at 5%level; ($?^2 = 0.05; df = 1$; table value=3.84)

Table 4.3.2 shows the statistical findings of association between knowledge and sex of the high school teachers. The chi-square analysis was employed to explicate the relation between these two entities and it was found to be statistically not significant association between knowledge and sex of the high school teachers.

**Table-4.3.3: Association between the knowledge on behavioural problems and education of the high school teachers.**

| S. No | Education | T. No (40) | Knowledge score | | | | Chi-square |
|---|---|---|---|---|---|---|---|
| | | | < Average | | >Average | | |
| | | | No | % | No | % | |
| 1 | Master degree with B.Ed | 19 | 14 | 63.64 | 5 | 27.78 | 8* |
| 2 | Master degree with M.Ed | 17 | 8 | 36.36 | 9 | 50 | |
| 3 | Master degree with M.Phil | 4 | 0 | 0 | 4 | 22.22 | |

'*'- Significant at 5% level; ($?^2$ – 0.05; df = 2; table value - 5.99)

Table 4.3.3 shows the statistical findings of association between knowledge and educational qualification of high school teachers. The chi-square analysis was employed to explicate the relation between these two entities and it was found to be statistically significant at 5% level. It implies that there is a significant association between knowledge and educational qualification of the high school teachers.

**Table-4.3.4: Association between the knowledge on behavioural problems and teaching experience of the high school teachers.**

| S. No | Teaching experience | T. No (40) | Knowledge score | | | | Chi-square |
|---|---|---|---|---|---|---|---|
| | | | < Average | | > Average | | |
| | | | No | % | No | % | |
| 1 | < 15 years | 30 | 21 | 95.45 | 9 | 50 | 10.91* |
| 2 | > 15 years | 10 | 1 | 4.55 | 9 | 50 | |

'*'- Significant at 5% level; ($?^2$0.05; df = 1; table value =3.84)

Table-4.3.4 shows the statistical findings of association between knowledge and teaching experience of the high school teachers. The chi-square analysis was employed to explicate the relation between these two entities and it was found to be statistically significant at 5% level. It implies that there is a significant association between knowledge and teaching experience of the high school teachers.

**Table-4.3.5: Association between the knowledge on behavioural problems and deals with which standard of children.**

| S. No | Standard of children | T. No (40) | Knowledge score | | | | Chi-square |
|---|---|---|---|---|---|---|---|
| | | | < Average | | > Average | | |
| | | | No | % | No | % | |
| 1 | Category-1 | 12 | 7 | 31.82 | 5 | 27.78 | $0.06^{NS}$ |
| 2 | Category-2 | 28 | 15 | 68.18 | 13 | 72.22 | |

'NS' – Not significant at 5% level; ($?^2$ = 0.05; df = 1; table value =3.84)

**Note :**

Category 1: Deals with X standard

Category 2: Deals with XI & XII standard

Table-4.3.5 shows the statistical findings of association between knowledge and deals with which standard of children. The chi-square analysis was employed to explicate the relation between these two entities and it was found to be not significant at 5% level. It implies that there is no significant association between the knowledge and deals with which standard of children.

**Table-4.3.6: Association between the knowledge on behavioural problems and high school teachers who had inservice educational programme.**

| S. No | Inservice education | T. No (40) | Knowledge score | | | | Chi-square |
|---|---|---|---|---|---|---|---|
| | | | < Average | | > Average | | |
| | | | No | % | No | % | |
| 1 | Yes | 22 | 6 | 27.27 | 16 | 88.89 | 15.19* |
| 2 | No | 18 | 16 | 72.73 | 2 | 11.11 | |

'*'- Significant at 5% level; ($?^2$ = 0.05; df= 1; table value =3.84)

Table 4.3.7 gives the outcome of association between knowledge and high school teachers who had inservice educational programme. The chi-square analysis was worked out to bring out the relation between these two entities and it was found to be statistically significant at 5% level. It implies that there is a significant association between knowledge and high school teachers who had inservice educational programme.

**Table-4.3.7: Cumulative table showing the significance of social demographic variables over the knowledge score**

| S. No | Socio-demographic variable | Chi-square value | P value | Results |
|---|---|---|---|---|
| 1 | Age | 4.01 | P<0.05 | * |
| 2 | Sex | 1.6 | P>0.05 | NS |
| 3 | Educational qualification | 8 | P<0.05 | * |
| 4 | Teaching experience | 10.91 | P<0.05 | * |
| 5 | Deals with which standard | 0.06 | P>0.05 | NS |
| 6 | Inservice educational programme | 15.19 | P<0.05 | * |

'*'-Significant (P<0.05); 'NS'-Not significant (P>0.05)

The cumulative outline of association between knowledge on behavioural problem and socio-demographic variables of a high school teachers under the study was given in the above table 4.3.8. Among the socio-demographic variables for association with level of knowledge, the four of these factors such as age, educational qualification, and teaching experience, inservice education was found to be statistically significant, others were not significant.

## DISCUSSION

This study is focused on the knowledge of high school teachers regarding selected behavioural problems among adolescents in a selected high school at Salem District.

**The discussion is described under the following headings**

- ✍ Socio-demographic variables of high school teacher.
- ✍ Knowledge of high school teachers regarding selected behavioural problems of adolescents.
- ✍ Association of knowledge of high school teachers regarding behavioural problems with selected socio-demographic variables.

**Socio-Demographic Variables of High School Teachers**

- ✍ Among the study group maximum number 65% (26)of teachers from the age group of below 40 years, and 35 %(14) of teachers were in the age group of above 40 years.
- ✍ In this study group, 45% (18) of the teachers were males and 55% (22) were females.
- ✍ Among the study group, 47.5% (19) of teachers have master degree with B.Ed and 42.5% (17) of them have master degree with M.Ed and 10% (4) of them have master degree with M.Phil.
- ✍ In this study 75% (30) of the teachers have below 15 years of experience in teaching and 25%(10) of them have above 15years of experience.

- In this study sample 30% (12) were deals with X standard and 70% (28) were deals with XI,XII standard.
- Another finding of the study is that 100% (40) of teachers had child psychology in their curriculum.
- Among the study sample 55% (22) of teachers were attended inservice education on child psychology and 45% (18) of teachers not attended inservice education on child psychology.

**Knowledge of High School Teachers with Selected Behavioural Problems**

Knowledge of high school teachers on selected behavioural problems are divided into three categories.

Below average - below 50%

Average - 50% to 70%

Excellent - above 70%

Overall mean score percentage of knowledge of school teachers regarding selected behavioural problems such as conduct disorder, emotional disorder, substance abuse is below average (34.09%) level.

In the area of conduct disorders, the mean score percentage of causes 37.75% ,general information is 39.05%,signs and symptoms is 35%,management is 34.54%.A study done by **Svedam L., (1994)** which also indicate the teachers have fair knowledge (42.6%) about conduct disorder. So, this study supports the findings of the present study.

The mean score knowledge of teachers regarding emotional disorder, general information 29.03%, causes32.4%, signs and symptoms 34.90%, management 27.5%.

The mean score knowledge of substance abuse, general information 38.56%,causes 41.38%,signs and symptoms23.20% and management 37.28%.

These results indicates that the teachers regarding below average level of knowledge regarding behavioural problems among adolescents in different areas such as general information, causes, signs and symptoms and its management. So, they need more education in child psychology inorder to effectively indentify and manage the students and made modification of the student's behavior.

**Association of Knowledge with Selected Demographic Variables**

The present study reveals knowledge of high school teachers regarding selected behavioural problems among adolescents is not influenced by the socio-demographic variables of teachers such as sex, deals with which standard of children and have no significant association with knowledge score of teachers. Age, teachers experience, education and participation in inservice education programme have high significant relationship with knowledge score that is found through chi-square analysis. Balasubramaniyam (1988) study also indicated that teachers

experience in teaching have significant relationship with knowledge score. So, the study supports the findings of the present study.

The study shows that the teachers need more education and training on adolescent behavioural problem, behavior therapy to improve their knowledge and help them to modify problematic children's behavior. This can be achieved by adding mental health information and education on psychological aspect of adolescents by the help of health and educational department.

## CONCLUSION

This chapter dealt with analysis and interpretation of the data collected from 40 teachers on behavioural problems of adolescents at selected high school Salem District.

# CHAPTER-V

## SUMMARY, FINDINGS, CONCLUSION, IMPLICATION AND RECOMMENDATION

This chapter presents a brief account of the summary, major findings, conclusion, implications and recommendations of the study.

### SUMMARY OF THE STUDY

The primary aim of the study is to assess the knowledge of high school teachers regarding selected behavioural problems among adolescents in a selected high school at Salem district.

### THE OBJECTIVES OF THE STUDY

1. To assess the knowledge of high school teachers regarding selected behavioural problems among adolescents.
2. To determine the relationship between the knowledge of high school teachers on behavioural problems with selected demographic variables such as age, sex, educational qualification, teaching experience.
3. To prepare a health education pamphlet regarding selected behavioural problems among adolescents.

Based on the literature reviewed and with the guidance from various subject experts, the investigator developed the conceptual frame work, methodology for the study and a data analysis plan , in a most effective and efficient way. The conceptual frame work adopted for this study is based on the Pender's Health promotion model.

In view of the nature of the problem selected for the study and the objectives to be accomplished, descriptive survey was considered as appropriate research approach for this study. The sample of the study comprised of 40 high school teachers working in Velasamy Chettiar Higher Secondary School, Omalur. The instrument used for the data collection was a semi-structured technique. The data was collected in the month of November 2010.

The knowledge of high school teachers regarding behavioural problems of adolescents were assessed and compared with selected socio demographic variables like age, sex, educational qualification, teaching experience and attendance of inservice education on child psychology by using descriptive as well as inferential statistics.

**MAJOR FINDINGS OF THE STUDY**

The major findings of the study are summarized as follows,

**Findings related to sample characteristics**

- Among 40 samples 26(65%) were below 40 years of age and 14(35%) were above 40 years.
- Among 40 subjects 18(45%) were male 22(55%) were female teachers.
- 19(47.5%) teachers have master degree with B.Ed and 17(42.5%) have master degree with M.Ed and 4(10%) of them have master degree with M.Phil.

- Among 40 teachers 12(30%) were deals with X standard and 28(70%) were deals with XI & XII standard.
- Out of 40 samples, 30(75%) teachers have below 15 years of experience and 10(25%) had above 15years of experience.
- All selected 40(100%) teachers had child psychology in their curriculum.
- Among 40 teachers, 22(55%) of them have participated in the inservice education on child psychology and 18(45%) of them not participated in the inservice education on child psychology.

**Findings related to knowledge score of teachers**

- The overall knowledge score of teachers regarding conduct disorder, emotional disorder, substance abuse were 34.09%.
- The mean score percentage of knowledge of teachers regarding general information-39.05%, causes-37.75%, signs and symptoms-35, and management-34.54%. The total mean score percentage of teachers knowledge on conduct disorder is 37.14%.
- The mean score percentage of knowledge of teachers regarding general information – 29.03%, causes-32.4%, signs and symptoms -34.90% , and management-27.5%. The mean score percentage of teachers knowledge on emotional disorder is about 32.73%.

? The mean score percentage of knowledge of teachers regarding general information-38.56%, causes-41.38%, signs and symptoms - 23.20, and management- 37.28%.The total mean score percentage of teacher's knowledge on substance abuse is about 33.76%.

**Findings regarding the relationship between the selected demographic variables and knowledge level of teachers**

The investigator tries to find out the relationship between the knowledge of teachers with age, sex, educational qualification, deals with which standard of children, teaching experience and participation of inservice education on child psychology. The chi-square test was used to determine the statistical significance of the mean score, it was found that sex, deals with which standard of children are not significant, but age, educational qualification, teaching experience, participation of inservice education on child psychology was significant at 5% (P>0.05) level.

**CONCLUSION**

Overall knowledge of teachers regarding selected behavioural problems were below average 34.09%. Since the present study revealed that the socio-demographic variables such as sex, deals with which standard of children had no influence, but age, educational qualification, experience of the teachers and their participation in inservice education regarding child psychology had influence on the knowledge score of the high school teachers. So the health education during training on regarding

behavioural problems of adolescents were very much essential for teachers to promote the adolescents behavior in a good manner. Health personnels who working in schools should take the responsibility to improve the knowledge of teachers in the area of behavioural problems among adolescents. The world will be brighter with well behaved adolescents. So the teachers should give more importance to the behavioural modification of the adolescents.

**IMPLICATIONS**

The findings of the study has implications in different branches of nursing profession. i.e nursing service , nursing education, nursing administration and nursing research. By assessing the knowledge of teachers regarding behavioural problems, we get a clear picture regarding different steps to be taken in all these fields to improve the knowledge of teachers about behaviourl problems of adolescents.

**Health Service**

Today the nursing practice is concentrating on preventive aspect than creative aspects, so the community health service has got an important role to improve the health of mankind. As a part of community health services, school health service is an important aspect where the nurse can work for a group of children and adolescents and will be able to provide adequate service to them. For providing full time service to the school children, adequate health personnel are not there in our country, so

the nurse should take help from school teachers, who are more respectful than any other persons in the community. The community health nurse should educate the teachers regarding selected behavioural problems adolescents. So the teachers can improve their knowledge regarding causes, signs and symptoms and management towards behavioural problems among adolescents.

Participation in the regular school health programme will be essential for the teachers to improve their understanding about behavioural problems of adolescents.

**Nursing Education**

- In-service education, workshop, skill training for identifying behavioural problems are some of the effective means of increasing teachers participation in school health service.
- The curriculum of the teacher training course, should have the content on behavioural problems among adolescents and that should be implemented and reviewed periodically in order to develop the necessary knowledge and skills required by the teachers in the area of behavioural problems of adolescents.
- The information booklet on “Selected behavioral problems among adolescents”, for self learning of teachers can be provided by the Department of education. The booklet must have a pictorial summary on behavioural problems in the areas of causes, signs and

symptoms and management, so that the information communicated will be meaningful and useful.

**Nursing Administration**

Nursing personal should be prepared to take a leadership role in educating school teachers regarding behavioural problems among adolescents. They should inculcate their interest in educating these teachers during their school visits and disseminate information about behavioural problems. Appointment of school health nurse in all the schools were helpful to concentrate on the mental health care of adolescents. Mental health services should include individual counseling, personal guidance programmes or services, periodical screening of behavioural problems and relaxation techniques.

**Nursing Research**

There should be more scope for research in this area to improve teacher's knowledge in early identification of behavioural problems among adolescents. Health education pamphlets can be prepared to improve teacher's knowledge regarding behavioural problems. There is a need for extensive research regarding counseling techniques, parenting techniques, communication skill in order to improve teacher's knowledge and in turn help bringing favorable attitude regarding behavioural problems of adolescents.

## RECOMMENDATIONS BASED ON THE STUDY

10. A quasi-experimental study can be done to observe the effect of programmed instruction on knowledge and skill of teachers in school health programme.
11. A formal continuing education programme must be conducted in all schools regarding selected behavioural problems among adolescents, it's identification and management.
12. A concentrated effort should be made by community health nurse to increase awareness among high school teachers and their role in the total school health services.
13. A comparative study may be conducted between rural and urban teachers regarding the knowledge on behavioural problems of adolescents.
14. A similar study may be done on nurses to find out their knowledge and role perception about behavioural problems of adolescents.
15. A study can be conducted in the community to identify the prevalence of behavioural problems among adolescents.
16. A similar study can be conducted to assess the knowledge of parents regarding behavioural problems of adolescents.
17. The study can be replicated using a large sample there by findings can be generalized to a large population.

18. A study can be carried out to assess the knowledge , attitude of teachers regarding emotional needs of adolescents.

**SUMMARY**

This chapter has dealt with summary, major findings of the study , conclusions, implication, and recommendations.

# REFERENCES

## TEXTBOOK


1. **Achar's**, (2003), *"Text book of paediatrics"*, 3rd edition, Chennai, Orient Long Man Publishers, Pp : 548-558.
2. **Ahuja N,(**2004), *"A short Text book of Psychiatry"*, 5th edition, Jaypee Brothers Medical Publishers, New Delhi,Pp:34-38
3. **Anupam Sachdeva**, (2007) *"Advances in Paediatrics"*, 1st edition, Jaypee Brothers Medical Publishers, New Delhi, Pp:1045-1056.
4. **Barbara. F. Weller**, (1991), *"Text Book of Paediatric Nursing''*, 1st edition, London, Bailliere Tindall Publications, Pp: 448-452.
5. **Basvanthappa B.T**,(2006), *"Nursing Research*", 5th edition, Jaypee Brothers, Mumbai,Pp:55-65
6. **Basvanthappa B.T,** (2007), *"Psychiatric Mental Health Nursing"*,1thedition, Jaypee Brothers Publication, NewDelhi:362-403.
7. **Broadribb's**, (2003), *"Introductory Paediatric Nursing"*, 6th edition, Philadelphia, Lippincott Publishers, Pp: 673-681.
8. **Cecilly Lynn Betz,** "*Text Book of Paediatric Nursing''*, 4th edition, London, Mosby's Publishers, Pp: 498-520.
9. **Denish F Polit, et.al,** (1995), *"Nursing Research Principles & methods*",5th edition, Newcentral Book Agency,Calcutta, Pp:280-285.

10. **Dorothy Marlow.R,** (2009), *"Text book of Paediatric Nursing"*, 6th edition, Philadelphia, Sounders Publications, Pp:1220-1227.
11. **Dutta.A.K**, (2007), *"Advances in Paediatrics''*, 1st edition, New Delhi, Jaypee Brothers, Pp:1000-1025.
12. **Forfar & Arneils**, (2003), *"Text book of Paediatrics''*, 6th edition, New York, Churchill Living Stone, Pp:687-698.
13. **Gail,W.Stuart**, (2009), *"Principals & Practice of Psychiatric Nursing"*, 9th edition, Mosby publication, Missouri, Pp: 282-328
14. ***Gupta, M.C.,*** *(2005), "Text book of Preventive and social Medicine",* 3rd edition, New Delhi, Jaypee Brothers, Pp:569-572.
15. **James, Mott**, (1988), *"Child Health Nursing"*, 1st edition, California, Addision Wesely, Pp:249-252.
16. **Jane Ball Ruth Bindler,** (1955), *"Paediatric Nursing"*, 1st edition, Norwalk, Appleton and Langer, Pp:763-772.
17. **Jaya Klossheres.N., Nancy Hat Field,** (2006), *"Introduction to Paediatric Nursing"*, 1st edition, Lippincott, Williams & Wilkins, Pp:1026-1032.
18. **Levin Momiess**, (1997), *"Essential of Paediatrics"*, 2nd edition, London, Churchill Livingstone, Pp:1709-1712.
19. **Lippincott William**, (2000), *"Psychiatric Nursing Made Incredibly Easy"*, 1st edition, Lippincott Williams& Wilkins Publications, London, Pp:395-474.

20. **Lynn.T. Staheli,** (2003), *"Fundamentals of Paediatric Nursing"*, 3rd edition, Lippincott, Williams & Wilkins, Pp:90-98.

21. **Margaret Heagarty.C., et.al**, (1997), *"Rypin's Intensive Reviews paediatrics"*, 1st edition, Lippincott, Philadelphia, New York, Raven Publishers, Pp:971-976.

22. **Mary C.Townsend,** (2007), *"Psychiatric Mental Health Nursing"* 5th edition, Jaypee Brothers Publications, New Delhi, Page No:411-448.

23. **Nelson, et.al,** (2006), *"Text book of Paediatrics"*, 17th edition, Philadelphia, Saunders, Pp:1078-1089.

24. **Parthsarathy. A,** (2006), *"IAP Text book of Paediatrics"*, 3rd edition, New Delhi, Jaypee Brothers, Pp: 577-579.

25. **Polit.D.E.Hungler,** (2003), *"Nursing Research"*, 7th edition, Philadelphia, USA, Lippincott Company, Pp:289-311.

26. **Potts Barbar, et.al**, (2003), "*Paediatric Nursing Care for Children and their families"*, Australia, Reprinted Delmar, Pp:333-334.

27. **Prabhakaran G.N.,** (2002), *"Preventive and Socio Medicine"*, 1st edition, New Delhi, Jaypee Brothers, Pp:174.

28. **Rogers,** (1996), *"Text book of Paediatrics Nursing"*, 3rd edition, London, Williams & Company, Pp:1255-1256.

29. **Sundar Rao, P.S.S, Richard.J**.,(2000), *"Introduction to Biostastics"* 3rd edition, New Delhi, Prentice Hall publication,Pp:112-113.

30. **Suraj Gupta,** (2004), *"The Short Text Book Of Paediatrics"*, New Delhi, Jaypee publications, Pp:569-571.

31. **Susan Power James,** (2000), *" Child Health Nursing"*, 3rd edition, Mosby Publication, California, Page No:963-993.

32. **Timothy.J.David**, (2005), *"Recent Advances in Nursing"*, 1st edition, New Delhi, Mosby company, Pp:25-27.

33. **Treece and Treece, (**2004), *"Elements of Research in Nursing''*, 1st edition, New Delhi, Mosby company, Pp:25-26.

34. **Wachter, Phillips,** (1985), "*Nursing Care of Children*",10th edition, Philodelphia, Lippincott company, Pp:41-43.

35. **Wong's**, (2006), *"Nursing Care of Children"*,7th edition, Missouri, Mosby Company, Pp:870-876.

**JOURNALS**


1. **Ambors Uchtenhagen**; "Substance use Problem in Developing Countries", *The International Journal of Public Health,* Sep-2004;vol.82(9);Pp:641.
2. **Anantkumar**, "Fostering Mental Health" *Health Action*, Jan 2008,vol23(1): Pp:16-19.
3. **Anat Brunstein Klomek,** "Teenage suicide", *Archives of Suicide Research*, July 2008, vol 13(2); Pp: 133-140.
4. **Baljeet Singh Saluja et.al;** "Drug Dependence in Adolescent(1978-2000); A Based Observation from North India". *The Indian Journal of Pediatrics;* May 2007;vol.74(5).Pp:455-458.
5. **Berit Groholt,M.D ,** "Suicide and Suicide Attempts in Adolescents", *American Academy of Pediatrics*, Oct 2008,vol 12(2); Pp:871-874
6. **Blumstein**, "youth Violence, Guns, and the Illicit- Drug Industry", *Journal of Criminal Law and Criminology*, Aug 2007, vol 2(4); Page No: 10-36.
7. **Boonomo Y.A;** "Teenage Drinking and the onset of Alcohol Dependence". *Journal of Addiction*; Dec.2004; vol.99(12). Pp:1520-1528.
8. **Brain Bull;** "Alcohol in Moderation; Is it Good for you", *Herald of Healt*h; July 2008;Pp:7-8.

9. **Burke J.D.Loeber R.et al**; "Inattention as a Key Predictor of Tobacco use in Adolescence". *Journal of Abnormal psychology*; May2007; vol.116(2); Pp:249-259.

10. **Clare Lomes;** "Nurses to Spot Drug Risk Children", *Nursing times*; April; Vol.103(14);Pp:6.

11. **Claude.J.Romer** , "Violence a preventable disease" *World Health*, Jan 2007,vol5(2);Pp: 4-6

12. **David S.Bennett,** "Depression Among Children with Medical Problems" *Journal of pediatric Psychology*, Jan 2007, vol 2(3); Pp: 149-169

13. **Dierker, et.al;** "Testing the Dual Pathway Hypothesis to Substance use in Adolescence and young adulthood", *Drug& Alcohol Dependence*, Feb 2007,vol.87(1);Pp:83-93.

14. **Dinn WM**; Cigarette Smoking in a Student Sample", *Journal of Addict Behavior*; Jan.2004;vol.29(1);Pp:107-126.

15. **Dipika Sur;Mukhopadhyar**; "A Study on Smoking Habits Among Slum Dwellers and the Impacts on Health & Economics", *Journal of the Indian Medical Association*; Sep2007; vol.105(9). Pp:492-496.

16. **Dr.Neelan Krishna;** "Combating Alcoholism"; *Health Action*; April 2007; Pp:25.

17. **Gardner TW**; "Attention and Adolescent Tobacco Use" , Journal of Addict Behavior;March2006;vol.31(3)Pp:531-536.

18. **Grekin E.R. et.al.,** "Personality and Substance Dependence Symptoms; Modeling Substance Specific Traits", *Psychology of Addictive Behavior*; Dec .2006;vol.20(4) Pp:415-424.

19. **Griffin. K.W.Nicholas et al.,** "Social Competence Among Urban Minority Youth Entering Middle School; Relationships with Alcohol use and antisocial Behaviours", *International Journal of Adolescence Medical Health*; Jan-2006;vol(1);Pp:97-106

20. **Haridas,R.M**, "Child and Adolescent Psychiatry", *Indian Journal of Psychiatry*; April 2007,vol14(3); Pp:5-9.

21. **Heflinger .C.A;** "Risk Factors For Serious Alcohol and Drug use the Role of Psychosocial Variables in Predicting the Frequency of Substance use among Adolescents", *American Journal of Drug and Alcohol Abuse* , 2006;vol32(3);Pp: 415-433.

22. **Hingson et al**; "Age at Drinking onset and Alcohol Dependence: Age at Onset, Duration and Severity", *Journal of Paediatric and Adolescence*, July2006;vol.160(7);Pp:739-746.

23. **Jory Richter,** Interrelation between temperament character and parental rearing among delinquent children, *Journal of Comprehensive Psychiatry,* March 2007, vol12(4); Pp:81-87

24. **Kaminer Y**; "Challenges and Opportu nities of Group Therapy for Adolescent Substance Abuse", *Journal of Addict Behaviour*, July 2005,vol.30(9);Pp:1765-174.

25. **Messeri P.A.** "Do Tobacco Counter Marketing Campaigns Increase Adolescents Under- Reporting of Smoking?" *Journal of Addict Behavior*; July 2007;vol.32(7)Pp:1532-1536.

26. **Mickey Ask**; "How to Beat Your Addiction", *Herald of Health*; May 2008, Pp:4-6

27. **Mushinski.M** "Teenagers view of violence and Social Tension in USA, Public Schools", State Bulletin of Metropolitan Insurance cooperation, July 2007,vol15(2); Pp:2-10.

28. **Nigg J.T, wong MM et al**., "Poor Response Inhibition as a Predictor of problem Drinking and Illicit Drug use in Adolescents at Risk for Alcoholism and Substance use Disorders", *Journal of American Academy Child Adolescence Psychiatry*; April 2006; vol.45(4) Pp:468-475

29. **NNT,** " Tobacco Free Youth", *Nightingale Nursing Times*; May 2008;vol.4(2);Pp:33

30. **NNT,** "DO Drugs Control Your Life", *Nightingale Nursing Journal*; June 2008 vol.4(3),Pp:21-23

31. **Sangaresh Nide Gundi;** "Substance Abuse", *Health Action*, Nov.2008, Pp:15-16.

32. **Selvaraj,** "A Study on Alcoholism Among Students", *Nightingale Nursing Times*, June 2007; vol 3(3); Pp:9-7.

33. **Senthim B.B and Manchandana** "Patterns of Drug use Among Male Students", *Indian Journal of Psychiatry*; 1978;vol20;Pp:166-173

34. **Sirvent Ruiz. C.et al.,** "Factors Related to Young People's Attitude to the Consumption of Alcohol and other Psychoactive Substances", *Journal of Psicothema*; Feb.2006;vol.18(1); Pp:52-64.

35. **Smolkowski;** "The Multilevel Structure of Four Adolescent Problems", *Journal of Preventive Science*, Sep 2007;vol 14(2).Pp:239-256.

36. **Young R.Sweeting et al**, "A Longitudinal Study of Alcohol Use and Antisocial Behavior in Young People", Alcohol; Mar-April 2008;vol.43(2);Pp:204-214

# APPENDIX-A

## LETTER SEEKING PERMISSION TO CONDUCT THE STUDY

From

**MS.V.UDHAYAKUMARI**

M.Sc.Nursing second year,

Vivekanandha College of Nursing

Elayampalayam.

To

**THE PRINCIPAL,**

Velasamy Chettiar Higher Secondary School,

Omalur,

Salem.

**Sub: Letter seeking permission to conduct the study.**

I **Ms.V.UDHAYAKUMARI,M.Sc(N)** year student (Child Health Nursing),Vivekananadha College of Nursing, Elayampalayam have undertaken a thesis on the topic **"A STUDY TO ASSESS THE KNOWLEDGE OF HIGH SCHOOL TEACHERS REGARDING SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS IN A SELECTED HIGH SCHOOL AT SALEM DISTRICT."**

**OBJECTIVES**

1. To assess the knowledge of high school teachers regarding selected behavioural problems of adolescents.
2. To determine the relationship between the knowledge of high school teachers on selected behavioural problems with selected demographic variables such as age, sex, educational qualification, teaching experience.
3. To prepare health education pamphlet regarding selected behavioural problems among adolescents.

I would request you to kindly grant me permission to conduct the study in your school and also issue necessary to the teachers to extend their co-operations to undertake my study successfully.

Thanking you,

Yours faithfully,

V.UDHAYAKUMARI

Place : Tiruchengode,

Date :

# APPENDIX –B

## LETTER GRANTING PERMISSION TO CONDUCT STUDY

From

**THE PRINCIPAL,**

Velasamy Chettiar Higher Secondary School,

Omalur,

Salem District.

**Subject: Permission to conduct the study in Velasamy Chettiar Higher Secondary School, Omalur, Salem District.**

With reference to the above letter, it has been informed that, **Ms.V.UDHAYAKUMARI** II year M.Sc(N) student, Vivekanandha College of Nursing, Elayampalayam, granted permission to conduct her study on "A study to assess the knowledge of high school teachers regarding selectedbehavioural problems among adolescents in a selected high school at Salem District."

In this regard the school teachers have been directed to provide full help and co-operation in facilitating the study.

With thanks,

Yours sincerely,

The Principal.

Place:

Date :

# APPENDIX-C

## LETTER FOR VALIDATION OF THE TOOL

From

**Ms.V.UDHAYAKUMARI,**

IIYear M.Sc Nursing,

Vivekanandha College of Nursing,

Elayampalayam.

To

Respected Sir/Madam

**Sub : Requisition for the content validation of the tool**

I **Ms.V.UDHAYAKUMARI** II year M.Sc Nursing student of Vivekanandha College of Nursing, Elayampalayam have taken a project on **"A STUDY TO ASSESS THE KNOWLEDGE OF HIGH SCHOOL TEACHERS REGARDING SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS IN A SELECTED HIGH SCHOOL AT SALEM DISTRICT."**

**OBJECTIVES OF THE STUDY**

1. To assess the knowledge of high school teachers regarding selected behavioural problems among adolescents.
2. To determine the relationship between the knowledge of high school teachers on selected behavioural problems with selected demographic variables such as age, sex, educational qualification, teaching experience.

3. To prepare health education pamphlets regarding selected behavioural problems among adolescents.

To achieve the above mentioned objectives, I have prepared a semi-structured questionnaire which consists of :

PART-A : Socio demographic data of teachers

PART-B :Knowledge related to selected behavioural problems

Section –I : knowledge related to conduct disorders

Section – II : knowledge related to emotional disorders

Section – III : knowledge related to substance abuse

I request you to kindly give your valuable opinion and suggestion. Kindly sign the enclosed certificate of validation stating that you have validated the tool.

Thanking you,

Yours faithfully,

**V.UDHAYAKUMARI**

**Enclosures**

1. Semi- structured questionnaire
2. Score –key
3. Evaluation Checklist
4. Certificate of validation

# APPENDIX-D

## LETTER SEEKING PERMISSION FROM THE PARTICIPANTS

Dear Participants,

I am **Ms.V.UDHAYAKUMARI, M.Sc.,** Nursing student of Vivekanandha College of Nursing, Elayampalayam is interested to know more about your knowledge on selected behavioural problems among adolescents. The information which you are giving will be kept confidential and will be used only for this study. Please participate in this program by answering my questions honestly and state your willingness to participate in this study.

Thanking you,

Name :

Signature :

## CONSENT FROM THE PARTICIPANT

I understand the purpose of this study and I am willing to participate in this study.

Signature

# APPENDIX –E

## SEMI STRUCTURED QUESTIONNAIRE

### PART-A : SOCIO –DEMOGRAPHIC DATA OF TEACHERS

**CODE NO :**

1. Age

1.1 < 30 years [ ]

1.2 31-40 years [ ]

1.3 41-50 years [ ]

1.4 > 50 years [ ]

2. Sex

2.1 Male [ ]

2.2 Female [ ]

3. Educational qualification

3.1 Degree with teacher training [ ]

3.2 Master degree with B.ED [ ]

3.3 Master degree with M.ED [ ]

3.4 Any other specify [ ]

4. Year of experience

4.1 1< 5 years [ ]

4.2 6-10 years [ ]

4.3 11-15 years [ ]

4.4 16-20 years [ ]

4.5 > 20 years [ ]

5 .Dealing which standard children?

5. 1 X standard children [ ]

5.2 XI standard children [ ]

5.3 XII standard children [ ]

6. Have you had child psychology in your curriculum?

6.1 Yes [ ]

6.2 No [ ]

7. Have you attended inservice education programme on behavioural problems of adolescents ?

7.1 Yes [ ]

7.2 No [ ]

If yes how often?----------

8. Do you find any child having behavioural problems in your class?

8.1 Yes [ ]

8.2 No [ ]

If yes, state the problem?----------

9. Do you think teachers play an important role in identifying the behavioural problems among adolescents?

9.1 Yes [ ]

9.2 No [ ]

10. Do you think moral education will mould the behaviour of the child?

10.1 yes [ ]

10.2 No [ ]

11. Whether curriculum change is necessary for the teachers to solve the behavioural problems of children?

11.1 Yes [ ]

11.2 No [ ]

## PART-B

## KNOWLEDGE RELATED TO SELECTED BEHAVIOURAL PROBLEMS

## SECTION-I

## KNOWLEDGE RELATED TO CONDUCT DISORDERS

1. Which age you call it as adolescents?

   1.1 10-13 years [ ]

   1.2 14-16 years [ ]

   1.3 17-19 years [ ]

2. What are the common behavioural disorders among adolescents?

   2.1 Conduct disorder [ ]

   2.2 Emotional disorder [ ]

   2.3 Substance abuse [ ]

3. What are the common conduct disorder seen in adolescent?

   3.1 Juvenile delinquency [ ]

   3.2 Aggression [ ]

   3.3 Stealing of other's property [ ]

   3.4 Run away from home and school [ ]

4. What are the causative factors for conduct disorder?

   4.1 Genetic factors [ ]

   4.2 Individual characteristics [ ]

   4.3 Community or society influence [ ]

   4.4 Family factors [ ]

   4.5 Abusive, violence [ ]

   4.6 Parental antisocial personality [ ]

5. What are the family factors cause conduct disorder?

5.1 Poor parent-child interpersonal relationship [ ]

5.2 Lack of father [ ]

5.3 Parental rejection [ ]

5.4 Lack of secure feeling [ ]

5.5 Large family size [ ]

5.6 Lack of love and affection [ ]

6. Which sex is mostly affected by conduct disorder?

6.1 Boys [ ]

6.2 Girls [ ]

6.3 Both sexes [ ]

7. What do you mean by delinquency?

7.1 Child who commits an offence [ ]

7.2 Destruction of property [ ]

7.3 Violence [ ]

7.4 Antisocial behaviour like committing sexual offences. [ ]

8. Which age group children's are called juvenile?

8.1 10-12 years [ ]

8.2 13-14 years [ ]

8.3 15-16 years [ ]

8.4 13-19 years [ ]

9. What are the causes of juvenile delinquency?

9.1 Poverty [ ]

9.2 Peer influence [ ]

9.3 Broken family [ ]

9.4 Financial problems [ ]

9.5 Lack of love and affection [ ]

9.6 Influence of mass media [ ]

9.7 Drug abuse include alcohol, smoking, drug abuse [ ]

10. What are the preventive measures of juvenile delinquency?

10.1 Training for parents to control the children [ ]

10.2 Healthy parent-child relationship [ ]

10.3 Improve the economic condition of the family [ ]

10.4 Counselling to the children [ ]

11. What do you mean by aggression?

11.1 Aggressiveness to people, animals [ ]

11.2 Destruction of property [ ]

11.3 Hitting, biting, kicking, fighting [ ]

11.4 Frequent conflict with peers [ ]

12. What are the causes of aggressive behaviour among adolescents?

12.1 Harsh discipline [ ]

12.2 Parental rejection [ ]

12.3 Severe punishment [ ]

12.4 Socially isolated children [ ]

13. How to identify the adolescent with aggressive behaviour?

13.1 Fighting with others [ ]

13.2 Use of nicknames [ ]

13.3 Spoiling of things [ ]

13.4 Disobedience [ ]

14. How to manage the adolescent with aggressive behaviour?

14.1 Special attention on child's activities [ ]

14.2 Provide moral education [ ]

14.3 Make the child to mingle with other children [ ]

14.4 More love and affection [ ]

14.5 Social skill training [ ]

14.6 Positive reinforcement for appropriate behaviours [ ]

14.7 Anger control programme [ ]

## SECTION -II

## KNOWLEDGE RELATED TO EMOTIONAL DISORDERS

15. What do you mean by emotional disorders?

- 15.1 Difficult to adjust with others [ ]
- 15.2 Lack of interest in doing work [ ]
- 15.3 Mistrust feeling [ ]
- 15.4 Felt bad on own self [ ]

16. What are the common emotional disorders seen in adolescents?

- 16.1 Anxiety [ ]
- 16.2 Depression [ ]
- 16.3 Suicide [ ]

17. Which sex is highly affected by emotional disorders?

- 17.1 Boys [ ]
- 17.2 Girls [ ]
- 17.3 Both sexes [ ]

18. What do you mean by anxiety?

- 18.1 Worrying [ ]
- 18.2 Stress [ ]
- 18.3 Fear [ ]
- 18.4 Deviation from normal feeling [ ]

19. What are the causes of anxiety?

- 19.1 Stress [ ]
- 19.2 Worrying about competence [ ]
- 19.3 Fear of school performance [ ]
- 19.4 Separation from home [ ]
- 19.5 Fear of teachers [ ]

20. What are the signs and symptoms of anxiety?

20.1 Fear of speaking in some situation [ ]

20.2 Excessive shy [ ]

20.3 Unpredictable panic attack [ ]

21. What are the physiological symptoms of anxiety?

21.1 Dryness of mouth [ ]

21.2 Cold & clammy hands and feet's [ ]

21.3 Elevated blood pressure [ ]

21.4 Excessive sweating, shivering [ ]

22. How will you identify the child with anxiety?

22.1 Restlessness [ ]

22.2 Difficulty in concentration [ ]

22.3 Inability to perform the activities [ ]

22.4 Disturbed sleep [ ]

23. How will you manage the child with anxiety?

23.1 Provide emotional support to the child [ ]

23.2 Parental counseling and family therapy [ ]

23.3 Anti-anxiety drugs [ ]

23.4 Helping of the child to adopt coping ability [ ]

24. What do you mean by depression?

24.1 Loneliness [ ]

24.2 Lack of interest [ ]

24.3 Feeling of helplessness [ ]

24.4 Feeling of sad [ ]

24.5 Sense of hopelessness [ ]

24.6 Suicidal ideations [ ]

25. What are the causes of depression?

25.1 Stresses of academic achievements [ ]

25.2 Family history of depression [ ]

25.3 Lack of love and affection [ ]

25.4 Harsh parenting styles [ ]

25.5 Abuse or neglect [ ]

25.6 Physical or emotional trauma [ ]

25.7 Loss of parent and relationship [ ]

26. How to identify the adolescent with depression?

26.1 Lack of interest to do activities [ ]

26.2 Withdrawal from peer group and family [ ]

26.3 Low in academic performance [ ]

26.4 Tendency to be alone [ ]

26.5 Sleeplessness and weight loss [ ]

27. What are the measures to manage the adolescent with depression?

27.1 Relaxation technique [ ]

27.2 Family education [ ]

27.3 Counselling to the student [ ]

27.4 Antidepressant drugs. [ ]

28. What do you mean by suicide?

28.1 Act of self injury [ ]

28.2 One who kill himself [ ]

28.3 Act of self damage [ ]

29. What are the common methods of suicide?

29.1 Hanging [ ]

29.2 Ingestion of drugs [ ]

29.3 Firearms [ ]

29.4 Poisoning. [ ]

30. Which sex has high incidence for suicide?

30.1 Boys [ ]

30.2 Girls [ ]

30.3 Both sexes [ ]

31. What are the causes of suicide?

31.1 Feeling of rejection [ ]

31.2 Loss of one or both parents [ ]

31.3 Lack of success in academic or athletic performance [ ]

31.4 Loss of friend [ ]

31.5 Depression [ ]

31.6 Financial problems of the family [ ]

31.7 Excessive stressful life events. [ ]

32. What are the risk factors for suicide?

32.1 Feeling of anxiety [ ]

32.2 Unmarried pregnancy [ ]

32.3 Drug abuse [ ]

32.4 Alcohol use [ ]

32.5 Fight with close friend [ ]

32.6 Shameful or humiliating experience [ ]

33. what are the warning signs of suicide?

33.1 Previous suicide attempt [ ]

33.2 Thoughts of wishing to kill self [ ]

33.3 Withdrawal from social activity [ ]

33.4 Poor concentration [ ]

33.5 Preoccupation with themes of death [ ]

33.6 Sudden change in school performance [ ]

34. What are the preventive measures of suicide?

34.1 Protective and safe environment [ ]

34.2 Ensuring adequate family support [ ]

34.3 Guidance and counselling to the individual [ ]

34.4 Family education [ ]

## SECTION-III

## KNOWLEDGE RELATED TO SUBSTANCE ABUSE

35. What is mean by substance abuse?

35.1 Use of any substance like alcohol, nicotine frequently & regularly [ ]

35.2 Excessive use of substance [ ]

35.3 Use of alcohol, nicotine and certain drugs against the medical and social norm [ ]

35.4 Improper use of substance [ ]

36. What are the common substances that can be abused?

36.1 Tobacco [ ]

36.2 Alcohol [ ]

36.3 Drugs (Amphetamines) [ ]

36.4 Narcotics [ ]

37. What is the commonest cause of abuse among adolescents?

37.1 Poverty [ ]

37.2 Availability of substances [ ]

37.3 Peer group pressure [ ]

37.4 Environment where the child lives [ ]

38. What are the signs and sy mptoms of substance abused person?

38.1 Impaired attention & concentration [ ]

38.2 Weight loss [ ]

38.3 Head ache [ ]

38.4 Lack of memory [ ]

38.5 Euphoria [ ]

38.6 Lack of energy and motivation [ ]

39. What is mean by alcoholism?

39.1 Drinking alcohol excessively [ ]

39.2 Drinking alcohol daily or regularly [ ]

39.3 Drinking alcohol frequently [ ]

40. What are the causes of alcoholism?

40.1 Parental alcoholism [ ]

40.2 Peer group influence [ ]

40.3 Stressful life events [ ]

40.4 Easy availability of alcohol [ ]

40.5 Influence of mass media [ ]

41. What are the signs and symptoms of alcoholism?

41.1 Increased pulse, blood pressure, temperature [ ]

41.2 Loss of self control [ ]

41.3 Nausea and vomiting [ ]

41.4 Insomnia [ ]

41.5 Sweating [ ]

42. What are the measures to treat alcoholism?

42.1 Group therapy [ ]

42.2 Behaviour therapy [ ]

42.3 Disulfiram drug therapy [ ]

42.4 Counselling to the individual [ ]

43. Which are the factors contributing to tobacco use among adolescents?

- 43.1 Peer pressure [ ]
- 43.2 Imitation of adult behaviour [ ]
- 43.3 Advertisements [ ]
- 43.4 Feeling of insecurity [ ]

44. What are the problems that arise due to cigarette smoking?

- 44.1 Lung cancer [ ]
- 44.2 Oral cancer [ ]
- 44.3 Emphysema [ ]
- 44.4 Laryngeal carcinoma [ ]
- 44.5 Foul smelling breath [ ]
- 44.6 Periodontal disease [ ]

45. What is the drug used for smoking?

- 45.1 Caffeine [ ]
- 45.2 Nicotine [ ]
- 45.3 Sedatives [ ]
- 45.4 Analgesics [ ]

46. What are the management of tobacco smoking?

- 46.1 Youth to youth programs [ ]
- 46.2 Individual counselling [ ]
- 46.3 Health education [ ]
- 46.4 Aversion therapy [ ]

47. Which are the drugs commonly abused by adolescents?

- 47.1 Cocaine [ ]
- 47.2 Opiates [ ]
- 47.3 Cannabis [ ]
- 47.4 Sedatives [ ]

48. What are the causes of drug abuse?

48.1 Curiosity [ ]

48.2 Lack of parental control [ ]

48.3 Parental rejection [ ]

48.4 Depression [ ]

48.5 Antisocial behavior [ ]

49. What are the physical changes occur in drug abuse adolescents?

49.1 Unexplained weight loss [ ]

49.2 Slurring speech [ ]

49.3 Redness of the eyes [ ]

49.4 Hoarseness of voice. [ ]

50. What are the academic changes seen in drug abuse adolescents?

50.1 Short term memory [ ]

50.2 Conflict with teachers [ ]

50.3 Falling grades [ ]

50.4 Refuse to go to school [ ]

51. What are the measures available to treat the adolescent with drug abuse?

51.1 Guidance & counselling to the individual [ ]

51.2 Good communication with family [ ]

51.3 Encourage parental support [ ]

52. What are the suggested measures to avoid behavioural problems among adolescents?

52.1 Self examination [ ]

52.2 Individual teaching [ ]

52.3 Constant supervision [ ]

## SCORE KEY

| Q.NO | CORRECT RESPONCE | SCORE |
|---|---|---|
| 1 | 1.1,1.2,1.3 | 3 |
| 2 | 2.1,2.2,2.3 | 3 |
| 3 | 3.1,3.2,3.3,3.4 | 4 |
| 4 | 4.1,4.2,4.3,4.4,4.5,4.6 | 6 |
| 5 | 5.1,5.2,5.3,5.4,5.5,5.6 | 6 |
| 6 | 6.1 | 1 |
| 7 | 7.1,7.2,7.3,7.4 | 4 |
| 8 | 8.4 | 1 |
| 9 | 9.1,9.2,9.3,9.4,9.5,9.6,9.7 | 7 |
| 10 | 10.1,10.2,10.3,10.4 | 4 |
| 11 | 11.1,11.2,11.3,11.4 | 4 |
| 12 | 12.1,12.2,12.3,12.4 | 4 |
| 13 | 13.1,13.2,13.3,13.4 | 4 |
| 14 | 13.1,13.2,13.3,13.4,13.5,13.6,13.7 | 7 |
| 15 | 15.1,15.2,15.3,15.4 | 4 |
| 16 | 16.1,16.2,16.3 | 3 |
| 17 | 17.2 | 1 |
| 18 | 18.1,18.2,18.3,18.4 | 4 |
| 19 | 19.1,19.2,19.3,19.4,19.5 | 5 |
| 20 | 20.1,20.2,20.3 | 3 |
| 21 | 21.1,21.2,21.3,21.4 | 4 |
| 22 | 22.1,22.2,22.3,22.4 | 4 |
| 23 | 23.1,23.2,23.3,23.4 | 4 |
| 24 | 24.1,24.2,24.3,24.4,24.5,24.6 | 6 |
| 25 | 25.1,25.2,25.3,25.4,25.5,25.6,25.7 | 7 |
| 26 | 26.1,26.2,26.3,26.4,26.5 | 5 |

| | | |
|---|---|---|
| 27 | 27.1,27.2,27.3,27.4 | 4 |
| 28 | 28.1,28.1,28.3 | 3 |
| 29 | 29.1,29.2,29.3,29.4 | 4 |
| 30 | 30.1 | 1 |
| 31 | 31.1,31.2,31.3,31.4,31.5,31.6,31.7 | 7 |
| 32 | 32.1,32.2,32.3,32.4,32.5,32.6 | 6 |
| 33 | 33.1,33.2,33.3,33.4,33.5,33.6 | 6 |
| 34 | 34.1,34.2,34.3,34.4 | 4 |
| 35 | 35.1,35.2,35.3,35.3,35.4 | 4 |
| 36 | 36.1,36.2,36.3,36.4 | 4 |
| 37 | 37.1,37.2,37.3,37.4 | 4 |
| 38 | 38.1,38.2,38.3,38.4,38.5,38.6 | 6 |
| 39 | 39.1,39.2,39.3 | 3 |
| 40 | 40.1,40.2,40.3,40.4,40.5 | 5 |
| 41 | 41.1,41.2,41.3,41.4,41.5 | 5 |
| 42 | 42.1,42.2,42.3,42.4 | 4 |
| 43 | 43.1,43.2,43.3,43.4 | 4 |
| 44 | 44.1,44.2,44.3,44.4,44.5,44.6 | 6 |
| 45 | 45.2 | 1 |
| 46 | 46.1,46.2,46.3,46.4 | 4 |
| 47 | 47.1,47.2,47.3,47.4 | 4 |
| 48 | 48.1,48.2,49.3,48.4,48.5 | 5 |
| 49 | 49.1,49.2,49.3,49.4 | 4 |
| 50 | 50.2,50.2,50.3,50.4 | 4 |
| 51 | 51.1,51.2,51.3 | 3 |
| 52 | 52.1,52.2,52.3 | 3 |
| | **TOTAL** | **216** |

# APPENDIX-F

## EVALUTION CRITERIA CHECKLIST FOR VALIDATION OF THE TOOL

## Instruction

The expert is required to go through the tool and the content and give your opinion in the column given in the criteria table. If the tool is not meeting the criteria please give your valuable suggestion in the remarks column.

| S.NO | CRITERIA | YES | NO | REMARKS |
|---|---|---|---|---|
| **1.** | **Demographic variables**<br>The items on base line data cover all aspects necessary for the study. | | | |
| 2. | **Semi structured questionnaire on knowledge on behavioural problems**<br>✍ Relevant to the topics of the study<br>✍ Content organization<br>✍ Language is simple and easy to understand<br>✍ Clarity of items used<br>✍ Any other suggestions | | | |

# APPENDIX –G

## CERTIFICATION OF VALIDATION

This is to certify that

Tool – Semi – Structured Questionnaire

PART-A : Socio demographic data of teachers

PART- B : Knowledge related to selected behavioural problems

Section–I : Knowledge related to conduct disorder

Section– II : knowledge related to emotional disorders

Section– III : Knowledge related to substance abuse.

Prepared by MISS. V.UDHAYAKUMARI, II year M.Sc nursing student of Vivekanandha College of Nursing to be used in her study title **" A STUDY TO ASSESS THE KNOWLEDGE OF HIGH SCHOOL TEACHERS REGARDING SELECTED BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS IN A SELECTED HIGH SCHOOL AT SALEM DISTRICT"** has been validated by me.

Signature

Name :

Designation :

Date :

# APPENDIX –H

## HEALTH EDUCATION PAMPHLET

### BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS

**ADOLESCENTS**

**Meaning**

The term adolescents is derived from Latin word "Adolescere" meaning "to change", "to grow", "to mature."

Adolescent period is defined by the WHO, as age group between 10 and 19 years of age. This can be divided into early (10-13years), middle (14-16 year), late (17-19years) adolescents.

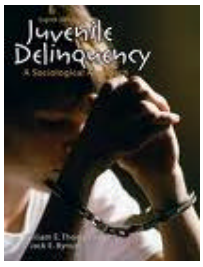
"Adolescents is a period of transition from childhood to adulthood." During this period, maximum amount of physical, psychological and behavioural changes takes place.

**BEHAVIOURAL PROBLEMS**

**Meaning**

Behavioural problems are thoughts or feeling or behavior differences the child is either suffering significantly or development in being significantly impaired.

**BEHAVIOURAL PROBLEMS AMONG ADOLESCENTS INCLUDE**




**Conduct Disorder**

- Juvenile delinquency
- Aggression

**Emotional Disorder**

- ? Anxiety
- ? Depression
- ? Suicide

**Substance Abuse**

- ? Smoking
- ? Alcoholism
- ? Drug abuse

**CONDUCT DISORDER**

**Meanin g**

Conduct disorder are characterized by a persistent and significant pattern of conduct in which the basic rights of others are violated or rules of society are not followed.

**JUVENILE DELINQUENCY**

**Meaning**

- ? A juvenile delinquent is a person between the ages of 15-17, who indulges in anti-social activity.
- ? Antisocial activity includes
- ? Destruction of other's property
- ? Stealing
- ? Run away from the home
- ? Vandalism

**Causes**

- ? Genetic factor
- ? Family factors like large family size, parental rejection, lack of father.
- ? Drug abu se include alcohol, smoking and drugs

? Poor economy

**PREVENTIVE MEASURES**

? Improvement of life

? Social welfare services

? Juvenile institutions and training schools

? Behavior therapy

**AGGRESSION**

**Meaning**

? It is destructive, injurious, hostile and often caused by frustration

**Causes**

? Genetic factors

? Feeling of anger

? Frustration

? Biochemical factors like increased level of testosterone

**Management**

? Provide emotional support to the child

? Parental counseling and family therapy

? Social skill training

? Positive reinforcement for appropriate behaviours

? Anger control program

**EMOTIONAL DISORDERS OR MOOD DISORDERS**

**Meaning**

? Mood disorder are disturbances in the regulation of mood, behavior and affect that go beyond the normal fluctuations that most people experience.

The most common mood disorders includes

- ? Anxiety
- ? Depression
- ? Suicide

**ANXIETY**

**Meaning**

- ? Anxiety is an emotional response (apprehension, tension, uneasiness) to anticipation of danger, the source of which is unknown or unrecongnized.

**Causes**


- ? Separation from home
- ? Difficulty in attending of school
- ? Fear to go to school
- ? Stress
- ? Fear of teachers

**Symptoms of Anxiety**

- ? Fear of speaking in the common places
- ? Refuse to go to school
- ? Unable answer
- ? Dryness of mouth
- ? Cold and clammy hands and feets
- ? Disturbed sleep.

**Management**

- ? Counseling to the individual
- ? Consultation with teachers and parents
- ? Helping the child to adopt coping ability
- ? Anti-anxiety drug

## DEPRESSION

### Meaning

- It is a syndrome of persistently sad or irritable mood accompanied by disturbances in sleep and appetite, lethargy and inability to experience pleasure.

### Causes of Depression

- Family history of depression
- Harsh parenting styles
- Loss of parents and relationship
- Excessive stress
- Lack of love and affection

### Symptoms of Depression

- Lack of interest to do activities
- Withdrawal from peer group and family
- Low in academic performance
- Tendency to be alone

### Management

- Relaxation technique
- Family education
- Counseling to the student
- Antidepressant drugs.

## SUICIDE

Meaning

- Suicide is a purposeful taking of one's own life or act of self destruction.

**Common Methods of Suicide**

- Hanging
- Ingestion of drugs
- Fire arms
- Poisoning



**Causes**

- History of previous attempts of suicide
- Excessive stressful life events
- Financial problems of the family
- Loss of one or both parents
- Depression

**Warning Signs of Suicide**


- Preoccupation with themes of death
- Withdrawl from social activity
- Sudden changes in school performance
- Poor concentration
- Thoughts of wishing to kill self.

**Preventive Measures of Suicide**

- Protective and safe environment
- Ensuring adequate family support
- Guidance and counseling to the individual
- Family education

## SUBSTANCE ABUSE

### Meaning

- Substance abuse refers to maladaptive pattern of substance use that impairs the health.
- Substance abuse is the repeated use of alcohol or other psychoactive drugs that leads to problems.

### Common Substance Abuse Among Adolescents Includes

- Smoking
- Alcoholism
- Drug abuse


## SMOKING

### Meaning

- Nicotine is the alkaloid in tobacco that causes dependence and is the most rapidly addicting drug.

### Causes of Smoking

- Peer pressure
- Imitation of adult behavior.
- Advertisements
- Feeling of insecurity
- Availability of cigarettes

### Effects of Smoking

- Lung cancer
- Laryngeal carcinoma
- Foul smelling breath

- ? Periodontal disease
- ? Oral cancer
- ? Emphysema.

**Management of Smoking**

- ? Youth to youth programmes
- ? Individual counseling
- ? Health education
- ? Aversion therapy

**ALCOHOLISM**

**Meaning**

- ? Alcohol (ethanol) is a CNS depressant that reduces the activity of neurons in the brain.

**Causes**

- ? Parental alcoholism
- ? Peer group influence
- ? Stressful life events
- ? Easy availa bility of alcohol
- ? Influence of mass media

**Symptoms**

- ? Loss of self control
- ? Nausea and vomiting
- ? Lack of sleep
- ? Loss of appetite
- ? Sweating
- ? Weakness in feet and legs
- ? Chills and trembling

**Management of Alcoholism**

- Group therapy
- Behavioural therapy
- Family therapy
- Aversive therapy
- Disulfiram therapy

**DRUG ABUSE**

**Meaning**

- Drug abuse is taking a drug for other than medical reasons and increased frequency, dose or manner that damages the physical or mental functioning.

**Causes**

- Curiosity
- Lack of parental control
- Parental rejection
- Depression
- Antisocial behavior
- Poor self image.

**Symptoms**

- Slurring of speech
- Unexplained weight loss
- Redness of the eyes
- Hoarseness of voice
- Short term memory
- Poor judgement
- Falling grades

**Management**

- ? Guidance and counseling to the individual.
- ? Good communication with family
- ? Encourage parental support
- ? School based health clinics
- ? Bring up healthy home environments

**CONCLUSION**

The health education booklet was prepared in the aspects of meaning, causes, signs and symptoms and management of behavioural problems among adolescents. This will help the teachers to identification and management the normal children with behavioural problems and modify their behavior in a healthy manner.